Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **NOEMI GALANTO BUSINE**	**Service Date**	:**08-May-2024**
Card No	: **I011-029-116777416-01**	**Health Provider**	:**Irham Medical Center Arjan**
Policy Holder	: **NOEMI GALANTO BUSINE**	**Doctor's Name**	:**SANDIA**
Payer Name	: **AL SAGR NATIONAL INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **20-05-2023** To **19-05-2024**		
Gender	: **Female**		
Date Of Birth	: **07-Jul-1987**		
Patient's Tel No	: **0561225287**		

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

Network : Green

Direct Access SP - YES

☐ **Acute** ☐ **Pre-existing and chronic** ☐ **Maternity**

Chief Complaints : pt comes with runny nose and blocked nose since a week. pt took antiallergic yesterday. no fever no other complain on examination nose4 is not inflamed chest is clear **Duration:**

Vitals: Temp : 36.5 Bp :115 Pulse :95 Resp :22

Clinical Findings:

Diagnosis: J30.9 - Allergic rhinitis, unspecified,R09.81 - Nasal congestion, **Date of Onset** :08/53/2024

Requested Investigations: 9, Consultation GP,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN **Estimated Cost** :

Prescriptions: 0070-148701-1171 - (LORATADINE : 10 MG) TABLETS,0252-185801-0391 - (DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS, **Estimated Cost** :

MEDICAL PRACTITIONER DECLARATION :

I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

PATIENT'S DECLARATION :

I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

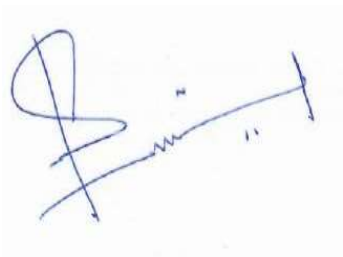
Dr's Name : SANDIA

Stamp :

Patient 's signature{Parent if minor} :

Date : 08-May-2024

Signature :



Date : 08-May-2024