Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: APRIL ROSE CABATO NUERA**
Card No	**: I011-029-116777370-01**
Policy Holder	**: APRIL ROSE CABATO NUERA**
Payer Name	**: AL SAGR NATIONAL INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 01-01-1900** To **19-05-2024**
Gender	**: Female**
Date Of Birth	**: 24-Apr-1986**
Patient's Tel No	**: 0551443084**

Service Date :10-May-2024 **Network** : Green

Health Provider :Irham Medical Center Arjan **Direct Access SP - YES**

Doctor's Name :SANDIA

Co-Insurance :

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

Remarks :

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

Chief Complaints : pt came for follow up known hypertensive on valsartan 80mg daily **Duration :**

Vitals: Temp : 36.7 Bp :124 Pulse :82 Resp :22

Clinical Findings:

Diagnosis: I10 - Essential (primary) hypertension, **Date of Onset** : 10/16/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Estimated Cost :

Prescriptions: 2138-166101-0391 - (VALSARTAN : 80 MG) FILM COATED TABLETS,

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.

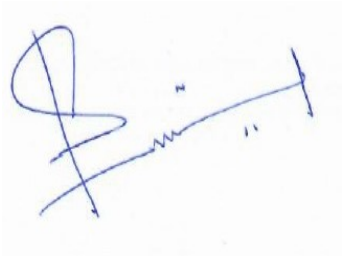
Dr's Name : SANDIA

Stamp :

Patient 's signature{Parent if minor} :

Date : 10-May-2024

Signature :



Date : 10-May-2024