Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: RAMY ROMEL DEEB**
Card No	**: I011-029-120730122-01**
Policy Holder	**: RAMY ROMEL DEEB**
Payer Name	**: AL SAGR NATIONAL INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 10-02-2024** To **09-02-2025**
Gender	**: Male**
Date Of Birth	**: 18-Sep-1992**
Patient's Tel No	**: 0585419924**

Service Date :18-May-2024 **Network** : Green

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

Doctor's Name **:Enomen Goodluck**

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 : C/o: Fever, pain in thraot, sweatiness, dry cough. He also has headache and generalized body pain. He is not hypertensive and not a known diabetic and has no other medical condition of note. ENT: Tonsils are markedly enlarged and almost kissing, with whitish and purulent spots all over it. **Duration:**

Vitals: Temp : 38.6 Bp :144 Pulse :107 Resp :18

Clinical Findings:

Diagnosis: J03.80 - Acute tonsillitis due to other specified organisms,J03.00 - Acute streptococcal tonsillitis, unspecified,J02.8 - Acute pharyngitis due to other specified organisms,R50.9 - Fever, unspecified, **Date of Onset** :18/58/2024

Requested Investigations: 96365, THER/PROPH/DIAG IV INF INIT,0195-107704-0801, CEFTRIAXONE-TABUK IV,0046-149902-0511, INFLA-BAN (DICLOFENAC SODIUM : 75 MG/3ML) INJECTION ,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,87075, CULTURE BACTERIAL ANY SOURCE ANAEROBIC ISO&ID,9, Consultation GP,96374, THER/PROPH/DIAG INJ IV PUSH,96372, THER/PROPH/DIAG INJ SC/IM **Estimated Cost :**

Prescriptions: 0005-119803-1171 - (PREDNISOLONE : 20 MG) TABLETS,4874-125821-3801 - (POVIDONE IODINE : 0.45%) SPRAY SOLUTION,1516-107902-1171 - (IBUPROFEN : 400 MG) TABLETS,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,0252-185801-0391 - (DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS,0139-116206-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS, **Estimated Cost :**

MEDICAL PRACTITIONER DECLARATION :

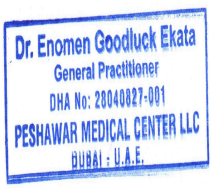
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

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.

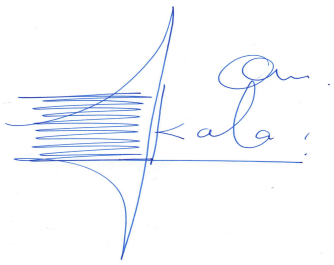
Dr's Name : Enomen Goodluck

Stamp :



Patient 's signature{Parent : if minor}

Date : 18-May-2024

Signature :  **Date :** 18-May-2024