Network

## **Administrative**

## **MEDICAL CLAIM FORM**

Claim Ref:

**Patient** 

: RAMY ROMEL DEEB

Service Date:19-May-2024

: Green

Name

Health

Provider Doctor's :Irham Medical Center Arjan

**Direct Access SP - YES** 

**Card No** Policy Holder

: 1011-029-120730122-01

: RAMY ROMEL DEEB

Name Co:Humaira

Payer Name: AL SAGR NATIONAL INSURANCE COMPANY

Insurance

Remarks

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

**TPA** 

: E CARE - Blue Network

: 10-02-2024 To 09-02-2025 Validity

: Male Gender

Date Of Birth

: 18-Sep-1992

Patient's Tel

Patient's Tel : 0585419924	l				
No . 0383419924	•				
Acute	te Pre-existing and chronic		☐ Maternity		
		lry cough. He also has headache	and <b>Duration</b> :		
generalized body pain. He is medical condition of note	s not hypertensive and not a kn	lown diabetic and has no other			
Vitals:Temp: 35.7 Bp:117 I	Pulse :72 Resn :18				
Clinical Findings:	uise :/2 Nesp :10				
Diagnosis: J03.80 - Acute to		organisms,J03.00 - Acute streptod d organisms,R50.9 - Fever, unspe	·	Date of :19/51/2 Onset	024
	D195-107704-0801, CEFTRIAXO ER/PROPH/DIAG INJ IV PUSH	NE-TABUK IV,9.01, Follow Up	Estimated : Cost		
Prescriptions:	Estimated Cost	:			
MEDICAL PRACTITIONER DECLARATION :			PATIENT'S 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.			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 . Humaira	Stamn ·	Dr. Humaira Mumtaz General Practitioner	Patient 's signature{Parent :		19- <b>Date</b> : May

Name

: Humaira

Stamp:

**General Practitioner** DHA No: 54155530-002 **PESHAWAR MEDICAL CENTER LLC** DUBAI - U.A.E.

signature{Parent: if minor}

Date: May-2024

Signature:

Date : 19-May-2024