Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **GABE EMMANUELLE MORCILLA . .**	**Service Date**	:**31-May-2024**
Card No	: **I011-029-120515766-01**	**Health Provider**	:**Irham Medical Center Arjan**
Policy Holder	: **GABE EMMANUELLE MORCILLA . .**	**Doctor's Name**	:**Humaira**
Payer Name	: **AL SAGR NATIONAL INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **01-07-2023** To **30-06-2024**		
Gender	: **Male**		
Date Of Birth	: **22-Sep-2002**		
Patient's Tel No	: **0589578846**		

Network : Green

Direct Access SP - YES

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

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

Chief Complaints : co cough cold running nose bodu ach headache 5 days molar teeth swellon oe enlarge and inflamed tonsills chest is congested no added sounds **Duration:**

Vitals: Temp : 36.2 Bp :124 Pulse :73 Resp :18

Clinical Findings:

Diagnosis: J03.90 - Acute tonsillitis, unspecified,R50.9 - Fever, unspecified,J30.9 - Allergic rhinitis, unspecified,R52 - Pain, unspecified, **Date of Onset** :31/59/2024

Requested Investigations: 0195-107704-0801, CEFTRIAXONE-TABUK IV,96374, THER/PROPH/DIAG INJ IV PUSH,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,85652, SEDIMENTATION RATE RBC AUTOMATED,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,96372, THER/PROPH/DIAG INJ SC/IM,0188-135906-2441, PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION,9, Consultation GP,94640, AIRWAY INHALATION TREATMENT **Estimated Cost** :

Prescriptions: 0005-119805-1171 - (PREDNISOLONE : 5 MG) TABLETS,0252-179601-1161 - (AMMONIUM CHLORIDE : N/A) (MENTHOL : N/A) (DIPHENHYDRAMINE : 14 MG/5 ML) SYRUP,0005-107001-0051 - (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS,0152-116604-0391 - (METRONIDAZOLE : 500 MG) FILM COATED TABLETS,0195-148602-0362 - (CLARITHROMYCIN : 500 MG) EXTENDED RELEASE 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 : Humaira

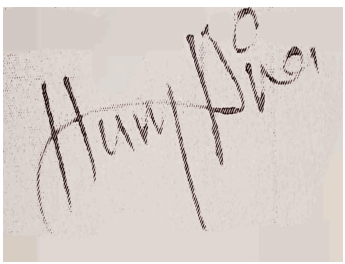
Stamp :

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

Patient 's signature{Parent if minor} :

Date : 31-May-2024

Signature :



Date : 31-May-2024