

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : VISHAL KUMAR CHAUDHARY

Card No : I011-029-119736610-02

Policy Holder : VISHAL KUMAR CHAUDHARY

Payer Name : AL SAGR NATIONAL INSURANCE COMPANY

TPA : E CARE - Blue Network

Validity : 19-06-2024 To 18-06-2025

Gender : Male

Date Of Birth : 06-Aug-1993

Patient's Tel No : 0523004789

Service Date :23-Jul-2024

Health Provider :CITICARE MEDICAL CENTER LLC

Doctor's Name :Humaira

Co-Insurance :

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

Remarks :

Network : Green

Direct Access SP - YES

☐ Acute

☐ Pre-existing and chronic

☐ Maternity

Chief Complaints : COfever on and off bodyache sweating nasal bleed 17th july 2024 oe enlarge and inflamed tonsills chest is clear no added sounds restless taking tablet at home penadol

Vitals:Temp : 36.5 Bp :124 Pulse :67 Resp :18

Clinical Findings:

Diagnosis: R50.9 - Fever, unspecified,J03.90 - Acute tonsillitis, unspecified,R04.0 - Epistaxis,K29.00 - Acute gastritis without bleeding,E86.0 - Dehydration, Date of Onset :23/44/2024

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,85652, SEDIMENTATION RATE RBC AUTOMATED,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,0195-107704-0801, CEFTRIAXONE-TABUK IV,0102-100104-1001, SODIUM CHLORIDE & DEXTROSE B.P.,96365, THER/PROPH/DIAG IV INF INIT,96372, THER/PROPH/DIAG INJ SC/IM,96360, HYDRATION IV INFUSION INIT,9, Consultation GP

Estimated : Cost

Prescriptions: 0005-107001-0051 - (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS,0207-533801-1451 - (ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) CAPSULES (HARD GELATIN),0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,0139-116206-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS, Estimated : Cost

Dr's Name : Humaira

Stamp :

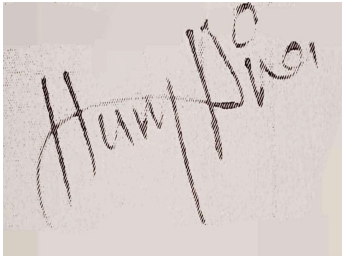
Dr. Humaira Mumtaz

General Practitioner

DHA No: 54155530-002

CITICARE MEDICAL CENTER LLC

DUBAI - U.A.E.

Signature :

Date : 23-Jul-2024

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.

Patient 's signature{Parent : if minor}



23-Jul-2024

https://irhamc.visionsoftwares.ae/mr_ecare_claim_print.aspx?appld=50107&patId=51341

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