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 :17-Nov-2024 **Network** : Green

Health Provider :CITICARE MEDICAL CENTER LLC **Direct Access SP - YES**

Doctor's Name :AHSAN HUSSAIN

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 : cofever on and off taking penadol at home dry cough running nose 7th nov. 2024 oe loose motion 17/11/2024 dehydration tongue dry 17/11/2024 chest is congested no added sounds restless smoker advise rest for one day **Duration:**

Vitals: Temp : 36.7 Bp :110 Pulse :68 Resp :18

Clinical Findings:

Diagnosis: R19.7 - Diarrhea, unspecified,J06.9 - Acute upper respiratory infection, unspecified,K29.00 - Acute gastritis without bleeding,E86.0 - Dehydration,J20.9 - Acute bronchitis, unspecified, **Date of Onset** :17/28/2024

Requested Investigations: 0102-152902-1001, LACTATED RINGERS INJECTION USP,96360, HYDRATION IV INFUSION INIT,0195-107704-0801, CEFTRIAXONE-TABUK IV,96365, THER/PROPH/DIAG IV INF INIT,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP **Estimated Cost** :

Prescriptions: 5278-912201-2891 - (DEXTROSE ANHYDROUS : 2.7 G/200ML (SODIUM CHLORIDE : 0.52 G/200ML (POTASSIUM CHLORIDE : 0.3 G/200ML (SODIUM CITRATE : 0.58 G/200ML (CITRIC ACID ANHYDROUS : 0.35 G/200ML ORAL LIQUID, **Estimated Cost** :

MEDICAL PRACTITIONER DECLARATION :

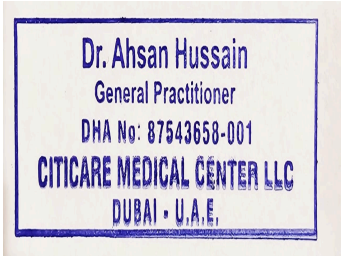
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

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 : AHSAN HUSSAIN

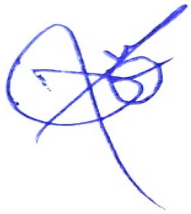
Stamp :



Patient 's signature{Parent if minor} :

Date : 17-Nov-2024

Signature :



Date : 17-Nov-2024