Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : SANDUN AROSHA
Card No : I011-029-119512841-01
Policy Holder : SANDUN AROSHA
Payer Name : AL SAGR NATIONAL INSURANCE COMPANY
TPA : E CARE - Blue Network
Validity : 04-03-2024 To 03-03-2025
Gender : Male
Date Of Birth : 24-Feb-1994
Patient's Tel No : 0568300534

Service Date :30-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 : pc: fever 29/11/2024 flu low back pain **Duration** :

Vitals: Temp : 38 Bp :130 Pulse :84 Resp :20

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,J20.9 - Acute bronchitis, unspecified,M54.5 - Low back pain,K21.9 - Gastro-esophageal reflux disease without esophagitis, **Date of Onset** :04/02/2024

Estimated Cost :

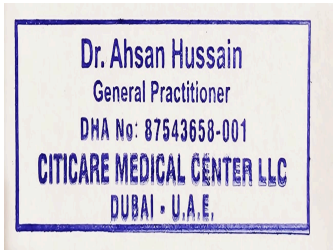
Requested Investigations: 9, Consultation GP

Prescriptions: 0027-265802-1161 - (BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V SYRUP,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,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS, **Estimated Cost** :

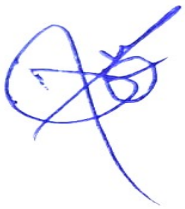
MEDICAL PRACTITIONER DECLARATION :

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.

Dr's Name : AHSAN HUSSAIN **Stamp :**



Signature :



Date : 04-Dec-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} :

Date : 04-Dec-2024