

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:14-Dec-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 flu sore throat cough

Duration :

Vitals:Temp : 37.5 Bp :120 Pulse :86 Resp :18

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,E86.0 - Dehydration, Date of Onset :18/30/2024

Requested Investigations: 0195-107704-0801, CEFTRIAXONE-TABUK IV,2190-106618-1001, Estimated :
PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,0125-122107-1022, Cost
DEXAMETHASONE SODIUM PHOSPHATE,0005-174202-0781, RISEK 40MG,96365, THER/PROPH/DIAG
IV INF INIT,96360, HYDRATION IV INFUSION INIT,96372, THER/PROPH/DIAG INJ SC/IM,0102-152902-
1001, LACTATED RINGERS INJECTION USP,0188-135906-2441, PULMICORT,94640, AIRWAY INHALATION
TREATMENT,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE
PROTEIN,9, Consultation GP,96374, THER/PROPH/DIAG INJ IV PUSH

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 :

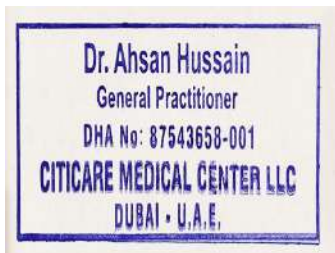
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

PATIENT'S DECLARATION :

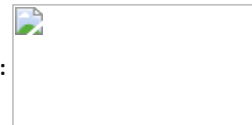
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : AHSAN HUSSAIN

Stamp :



Patient's signature{Parent : if minor}



Date : Dec-2024

Signature :

Date : 18-Dec-2024