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, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,0125-122107-1022, 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 **Estimated Cost :**

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 : 18-Dec-2024

Signature :

Date : 18-Dec-2024