

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : SHAILENDRA SINGH
Card No : I011-029-121356706-01
Policy Holder : SHAILENDRA SINGH
Payer Name : AL SAGR NATIONAL INSURANCE COMPANY
TPA : E CARE - Blue Network
Validity : 01-07-2024 To 30-06-2025
Gender : Male
Date Of Birth : 21-Jun-1990
Patient's Tel No : 0547272256

Service Date : 09-Jan-2025

Network : Green

Health Provider : CITICARE MEDICAL CENTER LLC

Direct Access SP - YES

Doctor's Name : Humaira

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 : co fever on and off pain in throat dry cough itching in the throat taken t. penadol 3 hrs before 6th jan. 2025 oe chest is congested no added sounds restless smoker

Duration:

Vitals: Temp : 36.6 Bp :120 Pulse :86 Resp :18

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified, J30.9 - Allergic rhinitis, unspecified, R05 - Cough, R50.9 - Fever, unspecified, K29.00 - Acute gastritis without bleeding,

Date of Onset : 17/47/2025

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT, 86140, C REACTIVE PROTEIN, 0188-135906-2441, PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION, 94640, AIRWAY INHALATION TREATMENT, 9, Consultation GP

Estimated : Cost

Prescriptions: 0005-116702-2481 - (DIPHENHYDRAMINE : 12.5 MG/5ML SYRUP (SUGAR FREE, 0207-533801-1451 - (ESOMEPRAZOLE (AS MAGNESIUM : 20 MG CAPSULES (HARD GELATIN, 0005-107001-0051 - (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS, 0097-127405-0391 - (AZITHROMYCIN : 500 MG FILM COATED 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 :

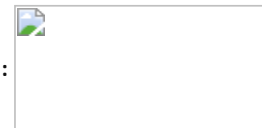
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Humaira

Stamp :



Patient's signature {Parent : if minor}



Date : Jan-2025

Signature :

Date : 17-Jan-2025