Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: MHD IYAD IBRAHIM BARGHALI**
Card No	**: I011-029-121055332-01**
Policy Holder	**: MHD IYAD IBRAHIM BARGHALI**
Payer Name	**: AL SAGR NATIONAL INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 20-01-2024** To **19-01-2025**
Gender	**: Male**
Date Of Birth	**: 27-May-1997**
Patient's Tel No	**: 0581991636**

Service Date :12-Jan-2025 **Network** : Green

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

Doctor's Name **:SANDIA**

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 : throbbing headache , photo sensitivity, high bp , anxious not able to sleep , 1 day known htn since 2015 on beta blocker since then bp was 160/90 ,he took beta blocker for that but bp was not controlled known hyperlipidemia not taking meds family hx of migrain , htn and hyperlipidemia(hypercholestrolemia) o/e : restless, anxious , red eyes , **Duration:**

Vitals: Temp : 36.7 Bp :133 Pulse :84 Resp :18

Clinical Findings:

Diagnosis: I10 - Essential (primary) hypertension,G43.711 - Chronic migraine w/o aura, intractable, w status migrainosus, **Date of Onset** :18/59/2025

Requested Investigations: 0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,96372, INJECTION SERVICE-IM,9, Consultation GP **Estimated Cost** :

Prescriptions: 0188-155602-0391 - (ROSUVASTATIN (AS CALCIUM) : 10 MG) FILM COATED TABLETS,0186-143702-0061 - (CELECOXIB : 100 MG) CAPSULES,4235-627102-1171 - (AMLODIPINE (AS BESYLATE : 10 MG (VALSARTAN : 160 MG TABLETS,5926-229701-1171 - (NEBIVOLOL (AS HCL : 5 MG TABLETS,1217-373201-2401 - (TOLPERISONE : 150 MG) SUGAR 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.

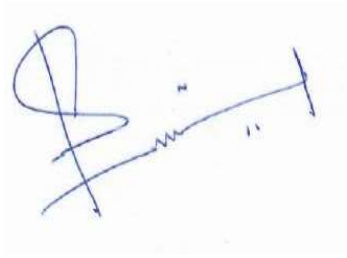
PATIENT'S DECLARATION :

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 : SANDIA **Stamp :**

Dr. Sandia Bhojwani
General Practitioner
DHA No: 65900212-001
PESHAWAR MEDICAL CENTER LLC
DUBAI - U.A.E.

Patient 's signature{Parent if minor} : **Date :** 18-Jan-2025

Signature :  **Date** : 18-Jan-2025