

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : VISHAL KUMAR CHAUDHARY
Card No : I011-029-119736610-01
Policy Holder : VISHAL KUMAR CHAUDHARY
Payer Name : AL SAGR NATIONAL INSURANCE COMPANY
TPA : E CARE - Green Network
Validity : 19-06-2023 To 18-06-2024
Gender : Male
Date Of Birth : 06-Aug-1993
Patient's Tel No : 971585513831

Service Date: 31-Oct-2023**Network**

: Green

Health Provider : Irham Medical Center Arjan**Direct Access SP - YES****Doctor's Name :** Sajid Sanaullah**Co-Insurance**

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

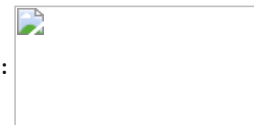
Remarks :
☐ Acute
 ☐ Pre-existing and chronic
 ☐ Maternity
 Chief Complaints : High fever and severe body pain and headache and severe illness since yesterday started on 30/10/2023**Duration:****Vitals:** Temp : 38.5 Bp :126 Pulse :85 Resp :22**Clinical Findings:**
Diagnosis: J02.9 - Acute pharyngitis, unspecified, J20.9 - Acute bronchitis, unspecified, R50.9 - Fever, unspecified, R05 - Cough,
 Date of Onset : 31/38/2023

Requested Investigations: 0195-107704-0801, CEFTRIAXONE-TABUK IV, 0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE, 0102-100104-1001, SODIUM CHLORIDE & DEXTROSE B.P., 0005-149902-1021, CLOFEN, 96360, HYDRATION IV INFUSION INIT, 96374, THER/PROPH/DIAG INJ IV PUSH, 94640, AIRWAY INHALATION TREATMENT, 0188-135906-2441, PULMICORT, 0006-124513-2071, VENTOLIN NEBULES, 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT, 86140, C REACTIVE PROTEIN, 85651, SEDIMENTATION RATE RBC NON AUTOMATED, 9, Consultation GP
 Estimated : Cost
Prescriptions: 0252-389802-1171 - (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE HCL : 30 MG) TABLETS, 0139-116206-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) 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 : Sajid Sanaullah**Stamp :**
Patient's signature{Parent : if minor}

Date : 31-Oct-2023
 Signature :
Date : 31-Oct-2023