Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **VISHAL KUMAR CHAUDHARY**	**Service Date**	:**31-Oct-2023**
Card No	: **I011-029-119736610-01**	**Health Provider**	:**Irham Medical Center Arjan**
Policy Holder	: **VISHAL KUMAR CHAUDHARY**	**Doctor's Name**	:**Sajid Sanaullah**
Payer Name	: **AL SAGR NATIONAL INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Green Network**	**Remarks**	:
Validity	: **19-06-2023** To **18-06-2024**		
Gender	: **Male**		
Date Of Birth	: **06-Aug-1993**		
Patient's Tel No	: **971585513831**		

Network : Green

Direct Access SP - YES

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

☐ **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.

Dr's Name : Sajid Sanaullah

Stamp :

Signature :

Date : 31-Oct-2023

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.

Patient 's signature{Parent : if minor}

Date : 31-Oct-2023