Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **VISHAL KUMAR CHAUDHARY**	**Service Date**	:**01-Nov-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	: **0523004789**		

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 CRP and lymphopenia in lab tests and severe sore throat still is there since 28/10/2023 **Duration:**

Vitals:

Clinical Findings:

Diagnosis: J02.9 - Acute pharyngitis, unspecified, **Date of Onset** : 01/13/2023

Requested Investigations: 9.01, Follow Up Consultation GP,0195-107704-0802, CEFTRIAXONE-TABUK IM,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,0005-111805-1021, CHLOROHISTOL 10MG,96372, THER/PROPH/DIAG INJ SC/IM **Estimated Cost** :

Estimated Cost :

Prescriptions:

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 : 01-Nov-2023

Signature :

Date : 01-Nov-2023