Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **NADEEM AHMAD SALIM KHAN**	**Service Date**	:**01-Nov-2023**
Card No	: **I011-029-119557476-01**	**Health Provider**	:**Irham Medical Center Arjan**
Policy Holder	: **NADEEM AHMAD SALIM KHAN**	**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	: **20-Feb-1983**		
Patient's Tel No	: **0554951623**		

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 : severe cough and wheezing and body pain since yesterday evening 31/10/2023 **Duration:**

Vitals: Temp : 37 Bp :100 Pulse :860 Resp :22

Clinical Findings:

Diagnosis: J18.0 - Bronchopneumonia, unspecified organism,J02.9 - Acute pharyngitis, unspecified,R50.9 - Fever, unspecified,R05 - Cough,R06.2 - Wheezing,E86.0 - Dehydration, **Date of Onset** :01/23/2023

Requested Investigations: 9, Consultation GP,0102-100104-1001, SODIUM CHLORIDE & DEXTROSE B.P.,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,0005-149902-1021, CLOFEN ,0005-111805-1021, CHLOROHISTOL 10MG,0195-107704-0801, CEFTRIAXONE-TABUK IV,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 **Estimated Cost** :

Prescriptions: 0005-116801-1162 - (SODIUM CITRATE : 57 MG/5ML) (AMMONIUM CHLORIDE : 131.5 MG/5 ML) (MENTHOL : 1.1 MG/5 ML) (DIPHENHYDRAMINE : 13.5 MG/5ML) SYRUP,0006-402804-2481 - (SALBUTAMOL(AS SULPHATE) : 2 MG/5ML) SYRUP (SUGAR FREE),4179-711202-0391 - (IBUPROFEN (AS L-ARGININE SALT) : 400 MG) FILM COATED TABLETS,0097-116206-0391 - (AMOXICILLIN : 875 MG) (CLAVULANIC ACID : 125 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 : Sajid Sanaullah

Stamp :

Patient 's signature{Parent : if minor}

Date : 01-Nov-2023

Signature :

Date : 01-Nov-2023