Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : **NADEEM AHMAD SALIM KHAN**
Card No : **I011-029-119557476-01**
Policy Holder : **NADEEM AHMAD SALIM KHAN**
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 : **20-Feb-1983**
Patient's Tel No : **0554951623**

Service Date :**03-Nov-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 : Severe cough and chest pain and severe weakness since 31/10/2023 again started symptoms today severe cough and wheezing **Duration:**

Vitals: Temp : 37.7 Bp :121 Pulse :86 Resp :22

Clinical Findings:

Diagnosis: J18.0 - Bronchopneumonia, unspecified organism,R06.2 - Wheezing,R06.03 - Acute respiratory distress,R05 - Cough,M62.81 - Muscle weakness (generalized), **Date of Onset** :03/22/2023

Requested Investigations: 9.01, Follow Up Consultation GP,0102-100104-1001, SODIUM CHLORIDE & DEXTROSE B.P.,0195-107704-0801, CEFTRIAXONE-TABUK IV,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,0005-111805-1021, CHLOROHISTOL 10MG,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,85651, SEDIMENTATION RATE RBC NON AUTOMATED,86140, C REACTIVE PROTEIN **Estimated Cost** :

Prescriptions: 0321-100604-1171 - (VITAMIN B12 : 200 MCG) (THIAMINE (VITAMIN B1) : 100 MG) (PYRIDOXINE (VITAMIN B6) : 200 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 : 03-Nov-2023

Signature :

Date : 03-Nov-2023