Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **DOHA MOHAMED MOHAMED FARID WAGDI**	**Service Date**	:**16-Nov-2023**
Card No	: **I011-029-119265996-01**	**Health Provider**	:**Irham Medical Center Arjan**
Policy Holder	: **DOHA MOHAMED MOHAMED FARID WAGDI**	**Doctor's Name**	:**Sajid Sanaullah**
Payer Name	: **AL SAGR NATIONAL INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Green Network**	**Remarks**	:
Validity	: **05-04-2023** To **04-04-2024**		
Gender	: **Female**		
Date Of Birth	: **20-Sep-1984**		
Patient's Tel No	: **0503566621**		

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 : feeling bad from 14/11/2023 and vomiting and difficult breathing. sever headache .period is irregular **Duration:**

Vitals: Temp : 36.6 Bp :106 Pulse :80 Resp :22

Clinical Findings:

Diagnosis: E03.9 - Hypothyroidism, unspecified,J03.91 - Acute recurrent tonsillitis, unspecified,J01.00 - Acute maxillary sinusitis, unspecified, **Date of Onset** :16/08/2023

Requested Investigations: 9, Consultation GP,84443, THYROID STIMULATING HORMONE TSH,84480, TRIIODOTHYRONINE T3 TOTAL TT3,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,96372, THER/PROPH/DIAG INJ SC/IM,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,0102-100104-1001, SODIUM CHLORIDE & DEXTROSE B.P.,0195-107704-0801, CEFTRIAXONE-TABUK IV **Estimated Cost** :

Prescriptions: 0252-107001-1171 - (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) TABLETS,0139-116207-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 500 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 : 16-Nov-2023

Signature :

Date : 16-Nov-2023