

## Administrative

## MEDICAL CLAIM FORM

## Claim Ref:

**Patient Name :** DOHA MOHAMED MOHAMED FARID WAGDI  
**Card No :** I011-029-119265996-01  
**Policy Holder :** DOHA MOHAMED MOHAMED FARID WAGDI  
**Payer Name :** AL SAGR NATIONAL INSURANCE COMPANY  
**TPA :** E CARE - Green Network  
**Validity :** 05-04-2023 To 04-04-2024  
**Gender :** Female  
**Date Of Birth :** 20-Sep-1984  
**Patient's Tel No :** 0503566621

**Service Date:** 16-Nov-2023  
**Health Provider :** Irham Medical Center Arjan  
**Doctor's Name :** Sajid Sanaullah

**Network :** Green  
**Direct Access SP - YES**

|              |               |        |           |     |           |        |
|--------------|---------------|--------|-----------|-----|-----------|--------|
| 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 :** 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 :**

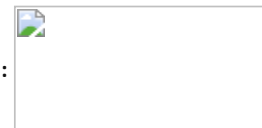
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

**Dr's Name :** Sajid Sanaullah

**Stamp :**



**Patient 's signature{Parent : if minor}**



**Date :** 16-Nov-2023

**Signature :**

**Date :** 16-Nov-2023