Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: MARIAM NAMWANJE**
Card No	**: I011-029-115723667-01**
Policy Holder	**: MARIAM NAMWANJE**
Payer Name	**: AL SAGR NATIONAL INSURANCE COMPANY**
TPA	**: E CARE - Green Network**
Validity	**: 21-08-2023** To **20-08-2024**
Gender	**: Female**
Date Of Birth	**: 25-Jan-1994**
Patient's Tel No	**: 0557294427**

Service Date :19-Dec-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 BURNING SENSATION WHEN URINATION SINCE 4 DAYS SINCE 15/12/2023 SEVERE FLANK PAIN AND BLADDER PAIN ALSO EXIST **Duration:**

Vitals: Temp : 36.9 Bp :105 Pulse :82 Resp :22

Clinical Findings:

Diagnosis: N39.0 - Urinary tract infection, site not specified,R30.0 - Dysuria, **Date of Onset :**19/32/2023

Requested Investigations: 0102-100104-1001, SODIUM CHLORIDE & DEXTROSE B.P.,0195-107704-0801, CEFTRIAXONE-TABUK IV,0005-149902-1021, CLOFEN ,96360, HYDRATION IV INFUSION INIT,96374, THER/PROPH/DIAG INJ IV PUSH,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,85651, SEDIMENTATION RATE RBC NON AUTOMATED,81007, URINALYSIS BACTERIURIA SCR XCPT CULTURE/DIPSTICK,87086, CULTURE BACTERIAL QUANTTATIVE COLONY COUNT URINE,9, Consultation GP,85025, COMPLETE BLOOD COUNT (CBC), BLOOD,83036, HBA1C, BLOOD,80061, LIPID PROFILE, MINI,10008, ECG,93306, Echocardiography (ECHO),80069, RENAL (KIDNEY) PROFILE, MINI **Estimated : Cost**

Prescriptions: 0097-103201-0391 - (CIPROFLOXACIN : 500 MG) FILM COATED TABLETS, **Estimated Cost :**

MEDICAL PRACTITIONER DECLARATION : **PATIENT'S 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.

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.

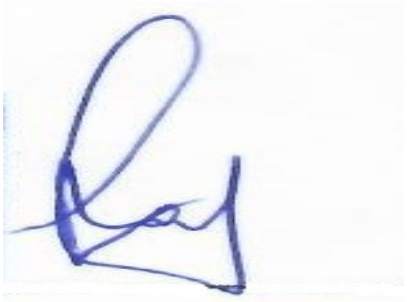
Dr's Name : Sajid Sanaullah

Stamp :

Patient 's signature{Parent if minor} :

Date : 19-Dec-2023

Signature :



Date : 19-Dec-2023