Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **JAHANGIR ALAM TAZUL ISLAM**	**Service Date**	:**23-Dec-2023**
Card No	: **I040-029-118710008-01**	**Health Provider**	:**Irham Medical Center Arjan**
Policy Holder	: **JAHANGIR ALAM TAZUL ISLAM**	**Doctor's Name**	:**Sajid Sanaullah**
Payer Name	: **UNION INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **02-01-2023** To **01-01-2024**		
Gender	: **Male**		
Date Of Birth	: **20-Apr-1978**		
Patient's Tel No	: **971563093585**		

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 : dry and wet cough, all muscular pain, pain in nasopharynx **Duration :**

Vitals: Temp : 37.5 Bp :130 Pulse :80 Resp :0

Clinical Findings:

Diagnosis: M79.10 - Myalgia, unspecified site,R05 - Cough,R50.9 - Fever, unspecified,J01.20 - Acute ethmoidal sinusitis, unspecified,R09.81 - Nasal congestion, **Date of Onset** :23/11/2023

Requested Investigations: 0195-107704-0801, CEFTRIAXONE-TABUK IV-(CEFTRIAXONE : 1 G) POWDER FOR INJECTION,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,0005-111805-1021, CHLOROHISTOL 10MG-(CHLORPHENIRAMINE MALEATE : 10 MG/ML) SOLUTION FOR INJECTION,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,0102-111908-1001, SODIUM CHLORIDE B.P.-(SODIUM CHLORIDE : 0.9% W/V) SOLUTION FOR INFUSION,96365, THER/PROPH/DIAG IV INF INIT,9, Consultation GP **Estimated Cost** :

Prescriptions: 0005-134001-1171 - (BROMHEXINE HYDROCHLORIDE : 8 MG) TABLETS,0005-116702-2481 - (DIPHENHYDRAMINE : 12.5 MG/5ML) SYRUP (SUGAR FREE),0355-123701-0392 - (CETIRIZINE HCL : 10 MG) FILM COATED 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 : 23-Dec-2023

Signature :

Date : 23-Dec-2023