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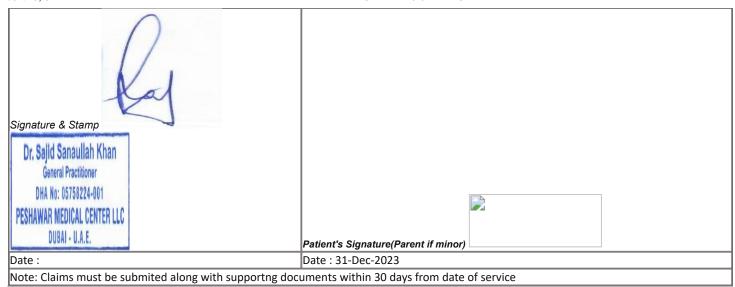


ADMINISTRATIVE The member is allowed for Out Patient at the Irham Medical Center Arjan Patent Name: **LINA HANI CHAHFEH** Gender: **Female** Validity Between: 13/02/2023 and 12/02/2024 **Coverage Informaton** 1/1/1996 12:00:00 Card No: 81A3-B2CA-87FB-5DED DOB: **Out Patient** AM RN UAE (Al Ansari-AUH)-Pin #: Identty Card: Network: **MEDGULF** Natonal ID: 784-1996-4151403-1 Service Date: 31-Dec-2023 Radiology: Covered Patent's Tel No: 0562754906 Threshold Policy Holder: Limit: **ORIENT INSURANCE** Normal Payer Name: Class: P.J.S.C Out-Patent: Patent's File 39503 Category: **Category B** Pharmacy: Co-Part: 20% No: Gatekeeper: No Consultation: Laboratory: Covered Referral No: Referred Service: SUBJECTIVE ASSESSMENT Symptom(s) as described by the patent (Chief Complaint): Date of Symptoms/illness started DD MM YYYY Complaint SEVERE SORE THROAT AND INABILITY TO SWALLOW AND VOMITING AND NAUSEA SINCE YESTERDAY 30/12/2023 Date of Symptoms/illness started Past Medical Surgical History? ○ Yes O No DD MM YYYY Date of Symptoms/illness started Obs/Gyn Claims DD MM YYYY ☐ Para ☐ Gravida: ☐ AB: LMP: Marital Status: Marital Date: What date did the Patient first feel same / similar Symptom(s) : dd mm yyyy Is the Patient under any type of Treatment? \bigcirc Yes \bigcirc No $\,$ if yes, indicate what Assessment and since when: OBJECTIVE / ASSESSMENT(To be completed by Physician) Clinical Findings: Vital Signs B/P: 114 T:37.2 HR: 78 RR

		: 22	1 . 37.2	1111 . 70	
Assessment/Diagnosis : CINDICATE DIAGNOS	Acute Chronic	Confirmed ○ Suspected			
Туре	Code	Diagnosis			
Primary	J02.9	Acute pharyngitis, unspecified			
Secondary	J20.9	Acute bronchitis, unspecified			
Secondary	K29.00	Acute gastritis without bleeding			
Secondary	R11.2	Nausea with vomiting, unspecified			
Secondary	R07.0	Pain in throat			

ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related illness/injury)

Accident or illness							
	Accident or illness due to work?		to road	Describe how the accide	scribe how the accident or work related injury/illness occur:		
○ Yes ○ No		○Yes	No				
Date of accident o	r beginning of illn	ess:		1			
MEDICAL PLAN Ite	mized Original In	voices and Applicable	Prescriptions	/ Reports / Results must b	oe enclosed	to consider claim	
CPT Code	Treatment					Туре	Price
9 CONSULTATION GP						General Consultation	25.0000
0006-124513- 2071	2071 VENTOLIN NEBULES						1.2300
0188-135906- 2441	PHIMICORI						10.4800
Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device						r, Co.Pay	20.0000
96361	Intravenous infusion, hydration; each additional hour (List separately in addition to code for primary procedure)						3.0000
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour						40.0000
0195-107704- 0801	7704- CEFTRIAXONE-TABUK IV						48.5000
0005-111805- 1021	5- CHLOROHISTOL 10MG						1.2000
0125-122107- 1022 DEXAMETHASONE SODIUM PHOSPHATE						Pharmacy	2.3400
0102-100104- 1001 SODIUM CHLORIDE & DEXTROSE B.P.						Pharmacy	4.5000
Code	Generic		Duration		Instruction	1S	
No Prescriptions I	History Found						
O Pharmacy: Estmated		Estmated Costs		O Laboratory / Radiology:		Estmated Costs	
0:		O Surgery:		○ Endoscopy:			
		O Physiotherapy:		Other Procedures:			
Is the following red	quired	O Physiotherapy:		Other Procedures:			
Is the following red	quired	O Physiotherapy:		If yes please specify			
				If yes please specify		F-F-	
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