

Administrative**MEDICAL CLAIM FORM****Claim Ref:**

Patient Name : MOHAMED BELAL
ABDELAZIZ MAHMOUD
SAAD

Card No : I040-029-118737797-01

Policy Holder : MOHAMED BELAL
ABDELAZIZ MAHMOUD
SAAD

Payer Name : UNION INSURANCE
COMPANY

TPA : E CARE - Blue Network

Validity : 01-01-1900 To 01-01-2025

Gender : Male

Date Of Birth : 12-Nov-1995

Patient's Tel No : 0588943992

Service Date :14-Jan-2024

Health Provider :Irham Medical Center Arjan

Doctor's Name :Sajid Sanaullah

Network : Green

Direct Access SP - YES

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 : c/ o severe pain and itching in throat since last 1 wk, hoarsness of voice since Duration: 2 days no cough ,fever is on & off since last 1 wk unable to eat properly because of swelling in throat		
Vitals:Temp : 36.4 Bp :109 Pulse :72 Resp :22		
Clinical Findings:		
Diagnosis: R52 - Pain, unspecified,J02.9 - Acute pharyngitis, unspecified,J03.90 - Acute tonsillitis, unspecified,R49.0 - Dysphonia,H92.02 - Otalgia, left ear,		
Requested Investigations: 0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,96365, THER/PROPH/DIAG IV INF INIT,96374, THER/PROPH/DIAG INJ IV PUSH,0195-107704-0801, CEFTRIAXONE-TABUK 1 GM IV,0005-111805-1021, CHLOROHISTOL 10MG-(CHLORPHENIRAMINE MALEATE : 10 MG/ML) SOLUTION FOR INJECTION,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86141, C TO REACTIVE PROTEIN HIGH SENSITIVITY,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,96360, HYDRATION IV INFUSION INIT,9, Consultation GP		Estimated Cost :

Prescriptions: 0207-632002-1751 - (PANTOPRAZOLE (AS SODIUM SESQUIHYDRATE) : 40 MG) GASTRO- **Estimated** :
RESISTANT TABLETS,2608-101701-0391 - (ACECLOFENAC : 100 MG) FILM COATED TABLETS,5362- **Cost**
330001-1171 - (PREDNISONONE : 10 MG) TABLETS,0009-127405-0391 - (AZITHROMYCIN : 500 MG) FILM
COATED TABLETS,

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.

Dr's Name : Sajid Sanaullah

Stamp :



Signature :

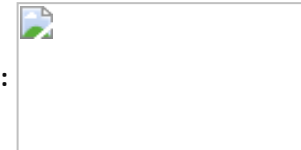


Date : 14-Jan-2024

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.

Patient 's signature{Parent : if minor}



Date : Jan-14-2024