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** **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 : 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, **Date of Onset** **:**14/17/2024

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-RESISTANT TABLETS,2608-101701-0391 - (ACECLOFENAC : 100 MG) FILM COATED TABLETS,5362-330001-1171 - (PREDNISONE : 10 MG) TABLETS,0009-127405-0391 - (AZITHROMYCIN : 500 MG) FILM COATED 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.

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 : 14-Jan-2024