

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : NARESH GAJJI
Card No : I035-029-115704914-01
Policy Holder : NARESH GAJJI
Payer Name : SALAMA – Islamic Arab Insurance Company
TPA : E CARE - Blue Network
Validity : 01-01-1900 To 06-08-2024
Gender : Male
Date Of Birth : 01-Jan-2000
Patient's Tel No : 582188520

Service Date : 22-Jan-2024
Health Provider : Irham Medical Center Arjan
Doctor's Name : Enomen Goodluck

Network : Green
Direct Access SP - YES

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: Generalized body pains, fever since 2 days, Also pain in throat. **Duration :**

Vitals:Temp : 37.2 Bp :126 Pulse :93 Resp :20

Clinical Findings:

Diagnosis: J02.8 - Acute pharyngitis due to other specified organisms, J20.9 - Acute bronchitis, unspecified, R50.81 - Fever presenting with conditions classified elsewhere, **Date of Onset :** 22/28/2024

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT, 86140, C REACTIVE PROTEIN, 85652, SEDIMENTATION RATE RBC AUTOMATED, 96374, THER/PROPH/DIAG INJ IV PUSH, 0195-107704-0801, CEFTRIAXONE-TABUK IV, 0005-149902-1021, CLOFEN , 0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION, 9, Consultation GP, 96372, THER/PROPH/DIAG INJ SC/IM **Estimated : Cost**

Prescriptions: 0005-116801-2481 - (SODIUM CITRATE : 57 MG/5ML) (AMMONIUM CHLORIDE : 131.5 MG/5 ML) (MENTHOL : 1.1 MG/5 ML) (DIPHENHYDRAMINE : 13.5 MG/5ML) SYRUP (SUGAR FREE), 2027-560101-0392 - (IBUPROFEN : 150 MG) (PARACETAMOL : 500 MG) FILM COATED TABLETS, 0097-127405-0391 - (AZITHROMYCIN : 500 MG) FILM COATED TABLETS, 0252-185801-0391 - (DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS, **Estimated : Cost**

MEDICAL PRACTITIONER DECLARATION :

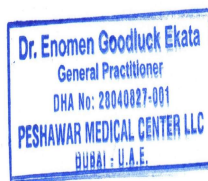
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

PATIENT'S DECLARATION :

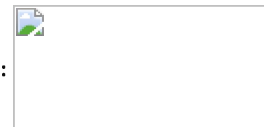
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Enomen Goodluck

Stamp :



Patient 's signature{Parent : if minor}



Date : 22-Jan-2024

Signature :

Date : 22-Jan-2024