

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : RAHUL THAKUR JOGINDER
Card No : I035-029-119648220-01
Policy Holder : RAHUL THAKUR JOGINDER
Payer Name : SALAMA – Islamic Arab Insurance Company
TPA : E CARE - Blue Network
Validity : 18-11-2023 To 17-11-2024
Gender : Male
Date Of Birth : 27-Jan-1999
Patient's Tel No : +919818890129

Service Date : 28-Jan-2024
Health Provider : Irham Medical Center Arjan
Doctor's Name : Sajid Sanaullah

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 : Severe abdominal pain and vomiting sine yesterday and high blood pressure **Duration:** since 27/1/2024

Vitals:Temp : 37.3 Bp :156 Pulse :84 Resp :22

Clinical Findings:

Diagnosis: K29.00 - Acute gastritis without bleeding,R11.2 - Nausea with vomiting, unspecified,Z91.018 - Allergy to other foods,L23.9 - Allergic contact dermatitis, unspecified cause,
 Date of Onset : 28/27/2024

Requested Investigations: 0102-100104-1001, SODIUM CHLORIDE & DEXTROSE B.P.,0248-122107-1021, DEXAMETHASONE SODIUM PHOSPHATE,0005-111805-1021, CHLOROHISTOL 10MG,0005-150403-1021, PREMOSAN ,0005-242802-0781, PANTONIX 40MG I.V.-(PANTOPRAZOLE (AS SODIUM) : 40 MG) POWDER FOR INFUSION,96365, THER/PROPH/DIAG IV INF INIT,96374, THER/PROPH/DIAG INJ IV PUSH,9, Consultation GP
 Estimated : Cost

Prescriptions: 0366-149801-0151 - (CLOBETASOL PROPIONATE : 0.05%) CREAM,0205-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,0031-168201-0391 - (DOMPERIDONE : 10 MG) FILM COATED TABLETS,0669-242802-3261 - (PANTOPRAZOLE (AS SODIUM) : 40 MG) DELAYED RELEASE TABLET,
 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 :

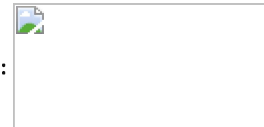
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Sajid Sanaullah

Stamp :



Patient 's signature{Parent : if minor}



Date : 28-Jan-2024

Signature :

Date : 28-Jan-2024