



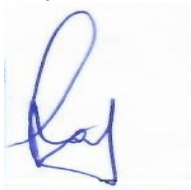
MEDICAL CLAIM FORM

Provider Name: Irham Medical Center Arjan	Patient Name: AHMED SAMY ABDELSALAM ALY ELKHOULY	
Insurance Company: AAFIYA MEDICAL BILLING SERVICES LLC	Patient Contact No: 0563607044	File No: 35080
Company Name:	Member ID: I007-026-119836122-01	
Date of Treatment : 20-Feb-2024	Date of Birth: 16-Jun-1985	Gender : Male

Chief Complaints : C/o: Chest pain since this morning, Said to have been awoken from sleep this morning by the pain. Pain is worst on breathing and on chest movement and change in posuure. Has associated difficulty breathing. There is no fever. There is no cough. There is no leg swelling, nor leg pain. Pain does not radiate to the left arm Acute pericarditis suspected, also pleurisy.			
Referral(if needed):			
Clinical Findings		BP: 106	TEMP: 36.8 HR: 64 RR: 20
Diagnosis: Chest pain, unspecified, Chest pain on breathing, Pleurisy, Acute pericarditis, unspecified		Diagnosis Code: R07.9, R07.1, R09.1, I30.9	Date of Onset 20-Feb-2024
PEC/CHRONIC ☐ CONGENITAL ☐ MATERNITY ☐ DENTAL ☐ OPTICAL ☐ WORK RELATED ☐ OTHERS ☐			

Treatment Plan: 9, GP Consultation,93000, Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report,85025, Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count,86140, C-reactive protein,,85652, Sedimentation rate, erythrocyte; automated,84484, Troponin, quantitative,71010, Radiologic examination, chest; single view, frontal,96372, Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular,0005-149902-1021, CLOFEN ,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION			
Requested Investigations :			Estimated Cost :
Prescription			Estimated Cost :
Medicine	Dose	Duration	
(NAPROXEN : 500 MG) TABLETS	TABLETS (20S, BLISTER PACK)	5	
(LEVOFLOXACIN (AS HEMIHYDRATE) : 500 MG) FILM COATED TABLETS	FILM COATED TABLETS (7S, BLISTER PACK)	7	

MEDICAL PRACTIONER 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 to Aafiya for purpose of determining Insurance benifits.
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Dr's Name : Sajid Sanaullah  Signature:		Stamp:  Date: 20-Feb-2024	 Patient's Signature(Parent If Minor): 20-Feb-2024 Date :
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Aafiya Medical Billing Services reserve its right during the Agreement period with the service provider, survey and audit the service provider's operations with respect to its performance of services, the patient visit details and claims.

24/7 Claims Centre

Helpline: 9714263 0666 | Tel: 971 4 283 8116 | Fax: 971 4 283 8115 | Email: claims@aafiya.ae | Website: www.aafiya.ae