

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : ANISH PARIYAR
Card No : I035-029-117534793-01
Policy Holder : ANISH PARIYAR
Payer Name : SALAMA – Islamic Arab Insurance Company
TPA : E CARE - Blue Network
Validity : 23-11-2023 To 22-11-2024
Gender : Male
Date Of Birth : 26-Apr-2002
Patient's Tel No : 0561509706

Service Date:28-Feb-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** : postular rashes all over on scalp but mainly in occipital region since 20 days **Duration**:**Vitals**:Temp : 36.8 Bp :128 Pulse :82 Resp :18**Clinical Findings**:**Diagnosis**: L08.9 - Local infection of the skin and subcutaneous tissue, unsp,L66.3 - Perifolliculitis capitis abscedens,**Date of Onset** :28/28/2024**Estimated Cost** :**Requested Investigations**: 9, Consultation GP,9, Consultation GP

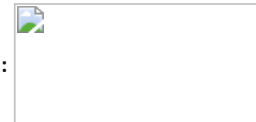
Prescriptions: 0005-128701-1453 - (TETRACYCLINE : 250 MG) CAPSULES (HARD GELATIN),0005-142801-1452 - (CEPHALEXIN : 500 MG) CAPSULES (HARD GELATIN),0009-149102-0431 - (CLINDAMYCIN : 1%) GEL,

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** : Feb-2024**Signature** :

Date : 28-Feb-2024