Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: Sagar Baraku**	**Service Date**	**:04-Mar-2024**	**Network**	**:** Green
Card No	**: I035-029-117534793-01**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	**: Sagar Baraku**	**Doctor's Name**	**:Sajid Sanaullah**		
Payer Name	**: SALAMA – Islamic Arab Insurance Company**				
TPA	**: E CARE - Blue Network**				
Validity	**: 23-11-2023** To **22-11-2024**				
Gender	**: Male**	**Remarks**	**:**		
Date Of Birth	**: 02-Feb-1990**				
Patient's Tel No	**: 0505284056**				

Co-Insurance :

CONSULTATION	LAB/ RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

☐ **Acute** ☐ **Pre-existing and chronic** ☐ **Maternity**

Chief Complaints : C/o: Neck pain, especially when trying to turn sideways. associated stiffness, but no headache, no photophobia and no phonophobia. Also has cough that is productive of clear sputum. **Duration:**

Vitals: Temp : 36.6 Bp :130 Pulse :80 Resp :22

Clinical Findings:

Diagnosis: J22 - Unspecified acute lower respiratory infection,J02.9 - Acute pharyngitis, unspecified,J30.9 - Allergic rhinitis, unspecified,M43.6 - Torticollis,J45.20 - Mild intermittent asthma, uncomplicated, **Date of Onset :**04/55/2024

Requested Investigations: 9, Consultation GP,94640, AIRWAY INHALATION TREATMENT, 0006-402803-2071, VENTOLIN NEBULES,0188-135906-2441, PULMICORT **Estimated Cost :**

Prescriptions: 1204-571401-1161 - (GUAIFENESIN : 100 MG/5ML) (PSEUDOEPHEDRINE HCL : 30 MG/ 5ML) (TRIPROLIDINE HCL : 1.25 MG/5ML) SYRUP,0188-272103-0791 - (BUDESONIDE : 160 MCG) (FORMOTEROL FUMARATE : 4.5 MCG) POWDER FOR INHALATION,0005-119803-1171 - (PREDNISOLONE : 20 MG) TABLETS,0139-116206-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS,0090-265901-1171 - (MONTELUKAST : 10 MG) TABLETS, **Estimated Cost :**

MEDICAL PRACTITIONER DECLARATION : **PATIENT'S 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.

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 :

Dr. Sajid Sanaullah Khan
General Practitioner
DHA No: 05758224-001
PESHAWAR MEDICAL CENTER LLC
DUBAI - U.A.E.

Patient 's signature{Parent : if minor}

Date : 04-Mar-2024

Signature :

Date : 04-Mar-2024