Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **MOHAMED BELAL ABDELAZIZ MAHMOUD SAAD**	**Service Date**	**:10-Mar-2024**
Card No	: **I040-029-118737797-01**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	: **MOHAMED BELAL ABDELAZIZ MAHMOUD SAAD**	**Doctor's Name**	**:Sajid Sanaullah**
Payer Name	: **UNION INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **01-01-1900** To **01-01-2025**		
Gender	: **Male**		
Date Of Birth	: **12-Nov-1995**		
Patient's Tel No	: **0588943992**		

Network : Green

Direct Access SP - YES

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: cough since the past 3 days, also has pain in throat and fever fever is high grade 39.4degree at presentation. **Duration:**

Vitals: Temp : 36.4 Bp :109 Pulse :72 Resp :22

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,J02.9 - Acute pharyngitis, unspecified,J03.90 - Acute tonsillitis, unspecified, **Date of Onset** :10/36/2024

Requested Investigations: 96365, THER/PROPH/DIAG IV INF INIT,0195-107704-0801, CEFTRIAXONE-TABUK IV,96372, THER/PROPH/DIAG INJ SC/IM,0005-149902-1021, CLOFEN ,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,0005-111805-1021, CHLOROHISTOL 10MG,9, Consultation GP **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),1516-107902-1171 - (IBUPROFEN : 400 MG) TABLETS,0005-119805-1172 - (PREDNISOLONE : 5 MG) TABLETS,0139-116206-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,0252-389802-1171 - (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE HCL : 30 MG) 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 : Sajid Sanaullah

Stamp :

Patient 's signature{Parent : if minor}

Date : 10-Mar-2024

Signature :

Date : 10-Mar-2024