Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: Karan Batra Vinod Kumar Batra**	**Service Date**	**:12-Mar-2024**	**Network**	**:** Green
Card No	**: I011-029-114468257-01**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	**: Karan Batra Vinod Kumar Batra**	**Doctor's Name**	**:Maimoona**		
Payer Name	**: AL SAGR NATIONAL INSURANCE COMPANY**	**Co-Insurance**	**:**		
TPA	**: E CARE - Blue Network**				
Validity	**: 08-03-2024** To **07-03-2025**				
Gender	**: Male**	**Remarks**	**:**		
Date Of Birth	**: 28-Mar-1988**				
Patient's Tel No	**: 565348759**				

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 : KNOWN HYPERTENSIVE MAINTAINED ON MEDICATION PRESCRIPTION REFIL **Duration:**

Vitals: Temp : 36.8 Bp :128 Pulse :80 Resp :22

Clinical Findings:

Diagnosis: I10 - Essential (primary) hypertension, **Date of Onset** : 12/20/2024

Requested Investigations: 9, Consultation GP **Estimated Cost** :

Prescriptions: 1394-627101-1171 - (AMLODIPINE (AS BESYLATE) : 5 MG) (VALSARTAN : 160 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 : Maimoona **Stamp :**

Patient 's signature{Parent : if minor}

Date : 12-Mar-2024

Signature :

Date : 12-Mar-2024