

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : Karan Batra Vinod Kumar
Card No : I011-029-114468257-01
Policy Holder : Karan Batra Vinod Kumar
Payer Name : AL SAGR NATIONAL INSURANCE COMPANY
TPA : E CARE - Blue Network
Validity : 08-03-2024 To 07-03-2025
Gender : Male
Date Of Birth : 28-Mar-1988
Patient's Tel No : 565348759

Service Date : 19-Mar-2024
Health Provider : Irham Medical Center Arjan
Doctor's Name : Enomen Goodluck
Co-Insurance :

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

Network : Green
Direct Access SP - YES

Remarks :

☐ Acute ☐ Pre-existing and chronic ☐ Maternity

Chief Complaints : C/O: Pain on the right flank since yesterday. Pain is described as waxing and waning. had a similar pain in the past and scan done showed he had a kidney stones. known hypertensive but not diabetic. has no other medical condition in the past. Current medications include: Lotevan Counselling on the need for hydration of at least 3L per day.

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

Clinical Findings:

Diagnosis: N20.2 - Calculus of kidney with calculus of ureter, **Date of Onset :** 19/07/2024

Requested Investigations: 96360, HYDRATION IV INFUSION INIT, 0195-107704-0801, CEFTRIAXONE-TABUK IV, 96372, THER/PROPH/DIAG INJ SC/IM, 0005-149902-1021, CLOFEN, 0005-136504-1021, SCOPINAL, 0102-111908-1001, SODIUM CHLORIDE B.P., 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT, 81001, URNLS DIP STICK/TABLET REAGENT AUTO MICROSCOPY, 86140, C REACTIVE PROTEIN, 9, Consultation GP, 96365, THER/PROPH/DIAG IV INF INIT

Prescriptions: 0114-274302-0391 - (LEVOFLOXACIN (AS HEMIHYDRATE) : 250 MG) FILM COATED TABLETS, 0053-111703-0251 - (SODIUM CITRATE : 630 MG) (TARTARIC ACID : 890 MG) (SODIUM BICARBONATE : 1.75 G) (CITRIC ACID : 720 MG) EFFERVESCENT GRANULES, 0135-223401-1171 - (NAPROXEN : 500 MG) TABLETS,

MEDICAL PRACTITIONER DECLARATION :

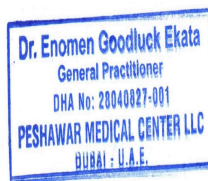
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

PATIENT'S DECLARATION :

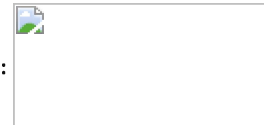
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Enomen Goodluck

Stamp :



Patient's signature {Parent : if minor}



Date : 19-Mar-2024

Signature :

Date : 19-Mar-2024