Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **MUHAMMAD MOHSIN ANWAR AHMAD**	**Service Date**	:**06-Apr-2024**
Card No	: **I011-029-112261443-01**	**Health Provider**	:**Irham Medical Center Arjan**
Policy Holder	: **MUHAMMAD MOHSIN ANWAR AHMAD**	**Doctor's Name**	:**Enomen Goodluck**
Payer Name	: **AL SAGR NATIONAL INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Green Network**	**Remarks**	:
Validity	: **05-10-2023** To **04-10-2024**		
Gender	: **Male**		
Date Of Birth	: **30-Jun-1995**		
Patient's Tel No	: **0585811284**		

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: Pain in throat, headache, dry mouth and generalized body pain from head to toe. Also has high grade fever that is minimally responsive to Panadol. Has associated difficulty breathing from blocked nostrils and nasal congestion. Not a known diabetic and not a known hypertensive. **Duration:**

Vitals: Temp : 36.8 Bp :117 Pulse :72 Resp :18

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,R06.00 - Dyspnea, unspecified,R50.9 - Fever, unspecified,R05 - Cough,J30.9 - Allergic rhinitis, unspecified, **Date of Onset** :06/44/2024

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,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,94640, AIRWAY INHALATION TREATMENT,0006-402803-2071, VENTOLIN NEBULES,0188-135906-2441, PULMICORT,96374, THER/PROPH/DIAG INJ IV PUSH,9, Consultation GP **Estimated Cost :**

Prescriptions: 0027-128802-2021 - (XYLOMETAZOLINE HYDROCHLORIDE : 0.1%) NASAL DROPS,0139-116207-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 500 MG) TABLETS,1516-107902-1171 - (IBUPROFEN : 400 MG) TABLETS,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,0252-185801-0391 - (DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED 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 :

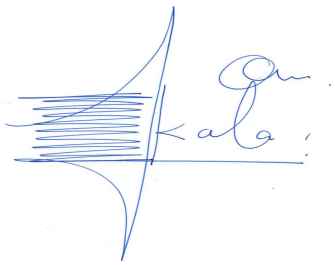
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Enomen Goodluck

Stamp :

Patient 's signature{Parent if minor} :

Date : 06-Apr-2024

Signature :  **Date** : 06-Apr-2024