Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: NADEEM AHMAD SALIM KHAN**
Card No	**: I011-029-119557476-01**
Policy Holder	**: NADEEM AHMAD SALIM KHAN**
Payer Name	**: AL SAGR NATIONAL INSURANCE COMPANY**
TPA	**: E CARE - Green Network**
Validity	**: 19-06-2023** To **18-06-2024**
Gender	**: Male**
Date Of Birth	**: 20-Feb-1983**
Patient's Tel No	**: 0554951623**

Service Date :06-Apr-2024 **Network** : Green

Health Provider **:Irham Medical Center Arjan** **Direct Access SP - YES**

Doctor's Name **:Enomen Goodluck**

Co-Insurance :

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

Remarks :

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

Chief Complaints : C/o: Pain in throat and coughing that is productive of clear sputum There is no fever. **Duration:**

Vitals: Temp : 36.6 Bp :110 Pulse :80 Resp :22

Clinical Findings:

Diagnosis: J02.8 - Acute pharyngitis due to other specified organisms,R07.0 - Pain in throat,R05 - Cough, **Date of Onset** :06/44/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 2027-560101-0392 - (IBUPROFEN : 150 MG) (PARACETAMOL : 500 MG) FILM COATED TABLETS,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),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.

Dr's Name : Enomen Goodluck **Stamp :**

Dr. Enomen Goodluck Ekata
General Practitioner
DHA No: 28040827-001
PESHAWAR MEDICAL CENTER LLC
DUBAI : U.A.E.

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

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.

Patient 's signature{Parent if minor} : **Date :** 06-Apr-2024