Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **Honney Zel Cordero Castanares**	**Service Date**	:**15-Apr-2024**
Card No	: **I011-029-116777372-01**	**Health Provider**	:**Irham Medical Center Arjan**
Policy Holder	: **Honney Zel Cordero Castanares**	**Doctor's Name**	:**SANDIA**
Payer Name	: **AL SAGR NATIONAL INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **20-05-2023** To **19-05-2024**		
Gender	: **Female**		
Date Of Birth	: **21-Dec-1992**		
Patient's Tel No	: **0508763906**		

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 : patient is 8 weeks pregnant, came for routine checkup. vitals se4ems normal **Duration:**
advised to see gynaecologist

Vitals: Temp : 37 Bp :111 Pulse :80 Resp :18

Clinical Findings:

Diagnosis: R11.2 - Nausea with vomiting, unspecified,J02.9 - Acute pharyngitis, unspecified,R42 - Dizziness and giddiness, **Date of Onset** :15/25/2024

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

Prescriptions: **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.

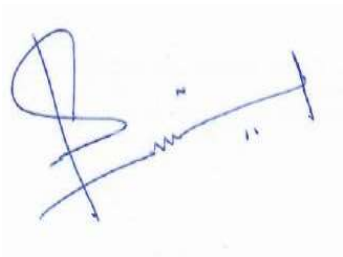
Dr's Name : SANDIA

Stamp :

Patient 's signature{Parent if minor} :

Date : 15-Apr-2024

Signature :



Date : 15-Apr-2024