Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **NADEEM AHMAD SALIM KHAN**
Card No	: **I011-029-119557476-02**
Policy Holder	: **NADEEM AHMAD SALIM KHAN**
Payer Name	: **AL SAGR NATIONAL INSURANCE COMPANY**
TPA	: **E CARE - Blue Network**
Validity	: **19-06-2024** To **18-06-2025**
Gender	: **Male**
Date Of Birth	: **20-Feb-1983**
Patient's Tel No	: **0554951623**

Service Date :**19-Aug-2024** **Network** : Green

Health Provider :**CITICARE MEDICAL CENTER LLC** **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 : RBS = 79mg/dl, High grade fever, pain in throat, nasal congestion, generalized body aches, and now weakness. Duration: 6days Has been on Panadol and some other medicines but no improvement. **Duration:**

Vitals: Temp : 38.1 Bp :120 Pulse :92 Resp :18

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,R50.9 - Fever, unspecified,M79.10 - Myalgia, unspecified site,R07.0 - Pain in throat,J30.9 - Allergic rhinitis, unspecified, **Date of Onset** :19/27/2024

Requested Investigations: 96365, THER/PROPH/DIAG IV INF INIT,0005-149902-1021, CLOFEN ,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,0195-107704-0801, CEFTRIAXONE-TABUK IV,2190-106618-1001, PARAFUSIV,96372, THER/PROPH/DIAG INJ SC/IM,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,82948, REAGENT STRIP/BLOOD GLUCOSE,9.01, Follow Up Consultation GP **Estimated Cost** :

Prescriptions: 0027-128802-2021 - (XYLOMETAZOLINE HYDROCHLORIDE : 0.1%) NASAL DROPS,0005-116702-2481 - (DIPHENHYDRAMINE : 12.5 MG/5ML) SYRUP (SUGAR FREE),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

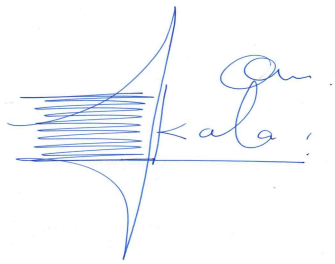
Stamp :

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

Patient 's signature{Parent if minor} :

Date : 19-Aug-2024

Signature :



Date : 19-Aug-2024