

Out-Patient

## Claim Form

CLAIM DATE : 14/02/2021

Incident #: 9540644



G00052225028

## Insured Member &amp; Provider Details

Member Name : RAED YOUSEF MUBARAK ALMEJABEL	CID : 271101200049	Member Mobile No. :
Affiliations/Doctor :Dr. Sarah Babu Namajada	Policy No. : 3602	Package : Kuwait Petroleum Company (KPC)
Provider Name :Al Salam International Hospital (H1)	Auth Status : REGISTERED	Specialty : Orthopedics

## Special Exclusions

## Waiting Period

## Chief Complaint &amp; Symptoms

Date of illness: / / (2021)  Chronic  Acute  Check Up  Maternity LMP: / / (2021)

## Diagnoses &amp; Treatments Details

Primary ICD 10: M19.67	PAIN IN FOOT AND TOES
Secondary ICD 10:	

Code	Description	Code	Description
<input type="checkbox"/> M06.4	Inflammatory polyarthropathy	<input type="checkbox"/> M06.9	Rheumatoid arthritis, unspecified
<input type="checkbox"/> M08.3	Unspecified juvenile rheumatoid arthritis, wrist	<input type="checkbox"/> M13.80	Other specified arthritis, unspecified site
<input type="checkbox"/> M23.329	Oth meniscus derang, post horn of medial meniscus, unsp knee	<input type="checkbox"/> M23.319	Oth meniscus derang, ant horn of medial meniscus, unsp knee
<input type="checkbox"/> M24.439	Recurrent dislocation, unspecified hip	<input type="checkbox"/> M24.50	Ankylosis, unspecified joint
<input type="checkbox"/> M25.50	Pain in unspecified joint	<input type="checkbox"/> M54.30	Sciatica, unspecified side
<input type="checkbox"/> M54.5	Low back pain	<input type="checkbox"/> M81.8	Other osteoporosis without current pathological fracture
<input type="checkbox"/> S13.8XXA	Sprain of joints and ligaments of oth prt neck, init enctr	<input type="checkbox"/> S56.919A	Strain of unsp musc/fasc/tend at forarm lv, unsp arm, init
<input type="checkbox"/> S83.249A	Oth tear of medial meniscus, current injury, unsp knee, init	<input type="checkbox"/> S83.99XA	Sprain of unspecified site of unspecified knee, init enctr
<input type="checkbox"/> S90.30XA	Contusion of unspecified foot, initial encounter	<input type="checkbox"/> S92.209A	Fracture of unsp tarsal bone(s) of unsp foot, init
<input type="checkbox"/> M25.519	Pain in unspecified shoulder	<input type="checkbox"/> M25.569	Pain in unspecified knee
<input type="checkbox"/> M25.579	Pain in unspecified ankle and joints of unspecified foot	<input type="checkbox"/> M25.80	Other specified joint disorders, unspecified joint
<input type="checkbox"/> M50.20	Other cervical disc displacement, unsp cervical region	<input type="checkbox"/> M41.8X9	Other specified deforming dorsopathies, site unspecified
<input type="checkbox"/> M51.37	Other intervertebral disc degeneration, lumbosacral region	<input type="checkbox"/> M51.6	Intervertebral disc disorders with myelopathy, lumbar region
<input type="checkbox"/> M65.30	Trigger finger, unspecified finger	<input type="checkbox"/> M54.2	Cervicalgia
<input type="checkbox"/> S13.5XXA	Sprain of ligaments of lumbar spine, initial encounter	<input type="checkbox"/> M62.89	Other specified disorders of muscle
<input type="checkbox"/> S63.90XA	Sprain of unsp part of unsp wrist and hand, init enctr	<input type="checkbox"/> M67.449	Ganglion, unspecified hand
<input type="checkbox"/> W19.0XXA	Unspecified fall, initial encounter	<input type="checkbox"/> S60.229A	Contusion of unspecified hand, initial encounter
		<input type="checkbox"/> S72.043A	Disp fx of base of neck of unsp femur, init for clx fx
		<input type="checkbox"/> S80.00XA	Contusion of unspecified knee, initial encounter

Plan	Code	Description	Requested (Qty/Days)	Approved (Qty/Days)	Service Date	Req Amount KD	Appr Amount KD	Member Amount KD	VISA No.	Remarks
2011	L80122	RANDOM BLOOD SUGAR	1 / 1	1 / 1	06/02/2021	8.000	8.000	4.828	16962706	
2011	L80067	CREATININE	1 / 1	1 / 1	06/02/2021	9.000	9.000	9.000	16962706	
Total						17.000	17.000	13.828		

I hereby certify that All information mentioned is correct and that the medical services on this form were provided and necessary for the management of this case

Physician's Signature.	Stamp	Date: 14/02/2021
I agree that if I have made or shall make any false or untrue statement, suppression or concealment, my right to claim reimbursement of the mentioned expenses shall be absolutely forfeited. I further hereby authorize any doctor, hospital, or medical provider, any insurance company or any other company, institution or any other person that has any record or information about me and/or any of my family members to provide GIG with the complete information's including copies of their records with reference to my sickness or accident, any treatment, examination, advice, or hospitalization. I agree that a copy of this consent shall have the validity of the original.	أقر ان بعلي وموافقتي على انه في حالة قياس بالادلاء ببيانات غير صحيحة أو خاطئة أو مخالفة لتوافق ومثالك في حال كتمان أو إخفاء اية بيانات لنقص حاجتي الصحية بانظمة مجموعه الخريج للتأمين بسقوط حتى في المطالبة بمسداد النفقات بشكل كامل وتلقائي. كما اقر بموافقتي على تفويض اي طبيب أو مقدم خدمة طبية بتزويد مجموعه الخريج لتأمين بكل المعلومات الشخصية الخاصة بي كاملة بما فيها نسخ سجلات الملفات الطبية الخاصة بحالتي الصحية والتأمين الطبي والفحوصات والعلاج بالمستشفيات. كما اقر بعلي التام وموافقتي على استخدام أي نسخة من هذا التفويض , وان اي نسخة منه تعتبر بمثابة نسخة اصلية.	
Insured Member.	Stamp	Date: 14/02/2021