



OMAN  
INTERNATIONAL  
HOSPITAL  
MANAGED BY IDEALMED GHS  
مستشفى عُمان الدولي  
بإدارة إيدال ميديكال

Al Afia Healthcare Development &  
Investment Company S.A.O.C  
Muscat  
CR No: 1281919  
Phone: 24903500  
E-mail: contact@omanihospital.com  
Website: www.omaniinternationalhospital.com

INVOICE NO. I  
OIHOP2022/73005



2022-10-31 - Original

## CIGNA International Corporation

Patient No. 9004952  
Name ALYAZEN HUSSAIN HASSAN S ALBALUSHI  
Policy No. 850927866-05  
Doctor Dr. Amal Zamzam

CR NO.: Consumidor Final

DESCRIPTION	UNIT	GROSS	DISCOUNT	PATIENT SHARE	INSURANCE PAYABLE
V.OP001040433 - Outpatient	2022/10/31 11:30 - 2022/10/31 11:30				EPISODE E.001125783
CONSULTATIONS		15.000			
Paediatrics Consultation - Specialist - First Consultation					
2022-10-31 10	1.00	15.000	0.000	3.000	12.000
Dr. Amal Zamzam					
		GROSS TOTAL	DISCOUNT	PATIENT SHARE	INSURANCE PAYABLE
		15.000	0.000	3.000	12.000

Patient Share: 3.000 Three Rial Omani  
CIGNA International Corporation Total: 12.000 Twelve Rial Omani



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**INVOICE NO. IR  
OIHOP2022/38506**



2022-10-31 - Original

**ALYAZEN HUSSAIN HASSAN S  
ALBALUSHI**

Patient No. 9004952  
Gender Male  
Birth Date 2018/11/07  
Mobile No. 92180799  
Nationality Oman  
CIGNA International Corporation  
Policy No. 850927866-05  
Payment Method CreditCard  
Number 9458  
Doctor Dr. Amal Zamzam

DESCRIPTION	UNIT	GROSS	DISCOUNT	PATIENT SHARE	INSURANCE PAYABLE
<b>V.OP001040433 - Outpatient</b>		2022/10/31 11:30 - 2022/10/31 11:30			EPISODE E.001125783
<b>CONSULTATIONS</b>		<b>15.000</b>			
Paediatrics Consultation - Specialist - First Consultation	1.00	15.000	0.000	3.000	12.000
2022-10-31 10 Dr. Amal Zamzam					
		<b>GROSS TOTAL</b>	<b>DISCOUNT</b>	<b>PATIENT SHARE</b>	<b>INSURANCE PAYABLE</b>
		15.000	0.000	3.000	12.000

Patient Share: 3.000 Three Rial Omani  
CIGNA International Corporation Total: 12.000 Twelve Rial Omani



## CIGNA International Corporation

Patient No. 9004952  
Name ALYAZEN HUSSAIN HASSAN S ALBALUSHI  
Policy No. 850927866-05  
Doctor Dr. Amal Zamzam

CR NO.: Consumidor Final

DESCRIPTION	UNIT	GROSS	DISCOUNT	PATIENT SHARE	INSURANCE PAYABLE
<b>V.OP001040433 - Outpatient</b>	2022/10/31 11:30 - 2022/10/31 11:30				EPISODE E.001125783
<b>EMERGENCY ROOM</b>		<b>16.000</b>			
Patient Observation between 1 to 3 hours					
2022-10-31 02.01.00.002 Dr. Amal Zamzam	1.00	16.000	0.000	0.000	16.000
<b>GENERAL PROCEDURES</b>		<b>16.000</b>			
IM/IV Medication Administration					
2022-10-31 03.01.00.0046 Dr. Amal Zamzam	1.00	8.000	0.000	0.000	8.000
Nebulization					
2022-10-31 12.03.00.004 Dr. Amal Zamzam	1.00	8.000	0.000	0.000	8.000
<b>V.OP001040507 - Outpatient</b>	2022/10/31 12:51 - 2022/10/31 12:51				EPISODE E.001125857
<b>LAB INVESTIGATIONS</b>		<b>63.000</b>			
CBC (Complete Blood Count)					
2022-10-31 85025 Dr. Amal Zamzam	1.00	9.000	0.000	0.000	9.000
CRP (C-REACTIVE PROTEIN)					
2022-10-31 86140 Dr. Amal Zamzam	1.00	9.000	0.000	0.000	9.000
ELECTROLYTES (NA;K;CL)					
2022-10-31 80051 Dr. Amal Zamzam	1.00	17.000	0.000	0.000	17.000
RENAL PROFILE (UREA,CR,URIC ACID,NA,K,CL) - Renal function panel This panel must include the following: Albumin (82040) Calcium, total (82310) Carbon dioxide (bicarbonate) (82374) Chloride (82435) Cre					
2022-10-31 80069 Dr. Amal Zamzam	1.00	28.000	0.000	0.000	28.000
		<b>GROSS TOTAL</b>	<b>DISCOUNT</b>	<b>PATIENT SHARE</b>	<b>INSURANCE PAYABLE</b>
		95.000	0.000	0.000	95.000

Patient Share: 0.000 None  
CIGNA International Corporation Total: 95.000 Ninety Five Rial Omani



## CIGNA International Corporation

Patient No. 9004952  
 Name ALYAZEN HUSSAIN HASSAN S ALBALUSHI  
 Policy No. 850927866-05  
 Doctor Dr. Amal Zamzam

CR NO.: Consumidor Final

DESCRIPTION	UNIT	GROSS	DISCOUNT	PATIENT SHARE	INSURANCE PAYABLE
<b>V.OP001040433 - Outpatient</b>		2022/10/31 11:30 - 2022/10/31 11:30		EPISODE E.001125783	
<b>PHARMACY</b>		<b>5.088</b>			
HYDROCORTISONE 100MG/2ML IM/IV INJECTION					
2022-10-31 M-000833	1.00	0.690	0.000	0.000	0.690
PULMICORT 0.5MG/1ML NEBULISER SUSPENSION 2ML RESPULES 20'S ( BUDESONIDE )					
2022-10-31 M-000873	1.00	0.878	0.000	0.000	0.878
PARACETAMOL KABI-10MG/ML SOLUTION FOR INFUSION, 100ML VIAL					
2022-10-31 M-001238	1.00	0.950	0.000	0.000	0.950
NEOMIT 4MG INJECTION IM/IV 2ML ( ONDANSETRON )					
2022-10-31 M-001777	1.00	1.890	0.000	0.000	1.890
0.9% SODIUM CHLORIDE 5ML (AMP)					
2022-10-31 M-001847	2.00	0.080	0.000	0.000	0.080
5% DEXTROSE - 0.225% SODIUM CHLORIDE 500 ML (BAG)					
2022-10-31 M-001888	1.00	0.600	0.000	0.000	0.600
<b>GROSS TOTAL</b>		<b>5.088</b>	<b>0.000</b>	<b>0.000</b>	<b>5.088</b>

Patient Share: 0.000 None

CIGNA International Corporation Total: 5.088 Five Rial Omani and Eighty Eight Baisa





## PRESCRIPTION

ALYAZEN HUSSAIN HASSAN S ALBALUSHI

Patient No. 9004952

Gender Male

Birth Date 2018/11/07

Mobile No. 92180799

Nationality Country Oman

Insurance CIGNA International Corporation

Policy No.

NO.	MEDICATION	INSTRUCTIONS	DURATION	QUANTITY	REFFIL
1	OMNICEF 125MG / 5ML SUSPENSION- 80 ML ( CEFDINIR )		5 days	1	
2	DAKTARIN ORAL GEL 2% 40GM ( MICONAZOLE )		5 days	1	TID
3	VENTOLIN 100MCG EVOHALER ( SALBUTAMOL )		6 days	1	
4	FLIXOTIDE 125MCG EVOHALER- 60 DOSES		30 days	1	
5	LUKRA PEDIATRIC ( MONTELUKAST ) 5MG TABLET 30'S		30 days	1	
6	STERIMAR BLOCKED NOSE BABY NASAL SPRAY 50ML		6 days	1	
7	LCET SYRUP ( LEVOCETIRIZINE ) SYRUP 100 ML	5ml	6 days	1	OD

*[Handwritten signature]*

Dr. Amal Zamzam

Doctor's signature



## PRESCRIPTION

**ALYAZEN HUSSAIN HASSAN S ALBALUSHI**

Patient No. 9004952

Gender Male

Birth Date 2018/11/07

Mobile No. 92180799

Nationality Country Oman

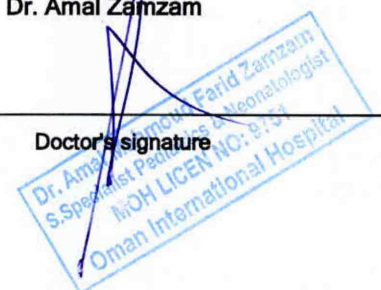
Insurance CIGNA International Corporation

Policy No.

NO.	MEDICATION	INSTRUCTIONS	DURATION	QUANTITY	REFIL
1	TYLENOL 200MG SUPPOSITORIES-10'S ( PARACETAMOL )		3 days	1	4h
2	JUSTIN 12.5 SUPPOSITORIES 5'S ( DICLOFENAC SODIUM )		3 days	1	6h
3	DOMPY 1MG/1ML ORAL SUSPENSION 200ML ( DOMPERIDONE )	3ml	3 days	1	BID

Dr. Amal Zamzam

Doctor's signature





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مستشفى عُمان الدولي  
بإدارة آي دي إل ميديكال

## LABORATORY REPORT

Report date: 31/10/2022

Patient ID: 9004952

Patient Name: ALYAZEN HUSSAIN HASSAN

Gender: FEMALE

Date of Birth: 07/11/2018

	TEST	RESULT	REF RANGE	UNITS
CBC	WBC	4.96	5.2 – 12.4	$10^3/\mu\text{L}$
CBC	RBC	4.46	4.2 – 6.1	$10^6/\mu\text{L}$
CBC	HGB	12.6	12.0 - 18.0	g/dL
CBC	HCT	37.0	37 - 52	%
CBC	MCV	83.0	80 - 99	fL
CBC	MCH	28.2	27 - 31	pg
CBC	MCHC	33.9	33 - 37	g/dl
CBC	RDW	15.0	11.5 – 14.5	%
CBC	PLT	150	130 - 400	$10^3/\mu\text{L}$
CBC	MPV	7.0	7.2 – 11.1	fL
CBC	NEUT%	79.9	40 - 74	%
CBC	LYMPH%	8.4	19 - 48	%
CBC	MONO%	7.1	3.4 - 9	%
CBC	EOS%	0.1	0.0 - 7	%
CBC	BASO%	0.8	0.0 - 1.5	%
CBC	NRBC%		0.0 - 2.0	NRBC/100
CBC	NEUT#	3.96	1.9 – 8.0	$10^3/\mu\text{L}$



CBC	LYMPH#	0.41	0.9 – 5.2	$10^{-3}/\mu\text{L}$
CBC	MONO#	0.35	0.16 – 1.0	$10^{-3}/\mu\text{L}$
CBC	EOS#	0.0	0.0 – 0.8	$10^{-3}/\mu\text{L}$
CBC	BASO#	0.04	0.0 – 0.2	$10^{-3}/\mu\text{L}$
CBC	NRBC#		0.0 – 0.20	$10^{-9}/\text{L}$

Renal Function	Na	140	Adults ( Serum / Plasma )
			Serum 136–145 mmol/L (136–145 mEq/L) Plasma 136–145 mmol/L (136–145 mEq/L) Adults Urine Urine 40–220 mmol/L/24 hr (40–220 mEq/L/24 hr)

Renal Function	K	4.83	Adults ( Serum / Plasma )
			Serum 3.5–5.1 mmol/L (3.5–5.1 mEq/L) Plasma 3.4–4.5 mmol/L (3.4–4.5 mEq/L) Adults Urine Urine 25–125 mmol/L/24 hr (25–125 mEq/L/24 hr)

Renal Function	Cl	105	Adults ( Serum / Plasma )
			Serum 98–107 mmol/L (98–107 mEq/L) Plasma 98–107 mmol/L (98–107 mEq/L) Adults Urine Urine 110–250 mmol/L/24 hr (110–250 mEq/L/24 hr)

Renal Function	Urea	17	Adults ( Serum / Plasma ) 9–23 mg/dL (3.2–8.2 mmol/L) Adults Urine 12–20 g/day (0.43–0.71 mol/day)	
Renal Function	Creatinine	0.4	Adult Males ( Serum / Plasma ) 0.70–1.30 mg/dl ( 62–115 $\mu$ mol/L ) Adult females ( Serum / Plasma ) 0.55–1.02 mg/dL ( 49–90 $\mu$ mol/L ) Adult Males ( Urine ) 950–2490 mg/day (8.4–22.0 mmol/day) Adult females (Urine) 600–1800 mg/day (5.3–15.9 mmol/day)	
Renal Function	Uric Acid	8.1	Adult Males (Serum /Plasma ) 3.7–9.2 mg/dL (220–547 $\mu$ mol/L) Adult females ( Serum / Plasma ) 3.1–7.8 mg/dL (184–464 $\mu$ mol/L) Adults Urine 250–750 mg/day (1.48–4.43 mmol/day)	
CRP	C - Reactive protein ( CRP )	2.6	Adults ( Serum ) < 0.5	mg/dL




Dr. Mohamed Al Zaabi MD, FRCPath

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This form, duly completed and signed, should be returned,  
along with a detailed invoice to the following:  
billing e-mail: [bills@cigna.com](mailto:bills@cigna.com)  
Or billing address: P.O. Box 19612 • Greenock PA15 9DB • Scotland

## Provider claim form for direct payment of outpatient medical services

CLAIM ONLY VALID WITH PATIENT SIGNATURE.

### Patient information (on patient's Cigna membership card)

CIGNA ID (OR CIGNA PERSONAL REFERENCE NO.) 850927866-05

NAME - FIRST NAME Alyazan

DATE OF BIRTH (D/M/Y)

### Provider information

NAME OF HOSPITAL/CLINIC Oman International Hospital

NAME OF DOCTOR/SPECIALIST Dr. Abdulrazzak

PROVIDER ADDRESS

CITY/COUNTRY

### Services rendered (please also attach the invoice(s) and/or the prescription for medication when applicable)

DIAGNOSIS OR NATURE OF ILLNESS

AMOUNT OF EXPENSES

AMOUNT PAID BY PATIENT\*

\* TO CALCULATE THE PATIENT PORTION PLEASE REFER TO THE OUTPATIENT  
COVERAGE ON THE FRONT OR BACK OF THE CIGNA CARDS

BALANCE DUE BY CIGNA

I hereby certify that I or (a) Member(s) of my staff have/has rendered the services as described in attached invoice(s). I also confirm that, to the best of my knowledge, and as I have verified the patient's membership card, the patient treated is indeed the person named on this form.

DATE

PROVIDER'S SIGNATURE

PROVIDER'S STAMP AND NAME

### Patient's authorisation

- I hereby certify that I understand that this claim form will allow Cigna to settle (part of) the claim(s) related to my treatment directly with the health care provider. I hereby also authorise the above mentioned health care provider to provide Cigna's Medical Consultant with all information that may be relevant or necessary for the correct assessment of this claim. I hereby certify that I will not lay any claim to Cigna against monies receivable by the provider of medical services.
- I hereby agree to return the patient portion to Cigna in case there is a difference between the amount paid by Cigna to the provider and the covered expenses according to my plan benefits.
- I hereby certify that I received the services as described in the attached invoice(s).
- In view of a smooth administration of the contract and/or settlement of the insurance claim, and only for that purpose, I hereby give my specific and informed consent regarding the processing of the medical data concerning myself and/or the members of my family (article 7 of the Belgian law of December 8, 1992 concerning the data protection).

DATE

PATIENT'S SIGNATURE