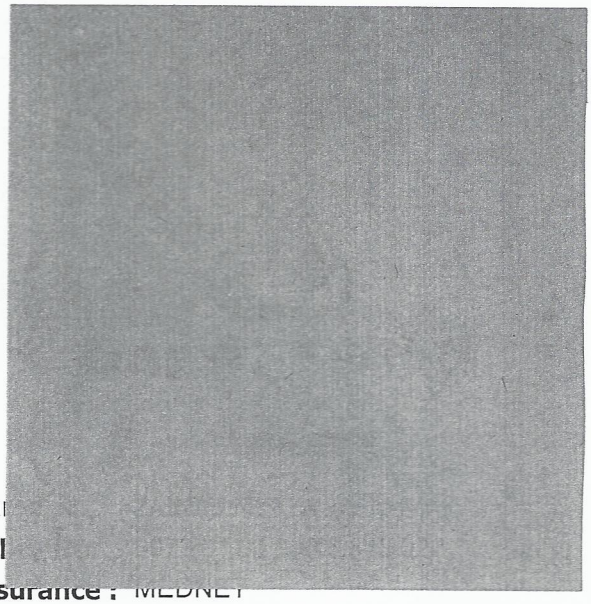
Tel : 17234242
Fax : 17251800
P.O.Box : 26968



DR. OSAMA FOUAD
Clinic

Invoice No : 013254
PReg No: 010807
C P R No: 780805755
Na
Pol
Insurance : MEDNET

Sex : Female
Visit Date : 29/03/2016
Doctor : DR. OSAMA FOUAD

	Services	Qty	Charges	Discount	Amount
1	Consultation - New	1.00	15.00	3.00	12.000
2	ROCEPHINE	2.00	34.00	8.50	25.500
3	VOLTAREN	2.00	12.00	2.40	9.600

06.9.14

Total Amount	:	**47.100**
Deduction	:	**5.000**
CO % Amnt	:	**0.000**
CO2 % Amnt	:	**0.000**
Net Total	:	**42.100**

[redacted]

mednet
The preferred choice for healthcare solutions

[redacted] RY MEDICAL CARE

Sr. No. 660641

[redacted] LLED BY THE INSURED MEMBER)

Member Name [redacted]	[redacted] surance Company/(Payer) TPA Name: Mednet
Membership /P [redacted]	[redacted] licy Holder: Mumtalakat
Date of Birth: [redacted]	[redacted] R/Passport Number: 780805755
Gender: M ☐ F ☑	Member's Phone Number: 38880838
Medical Record No: 10807	Provider Name: Dr. Osama Fouad clinic
Date of Treatment: 29/3/2016	

SECTION B: MEDICAL SECTION *(TO BE FILLED ONLY BY THE TREATING PHYSICIAN)*

Main Complaint & Presenting Symptoms:	Clinical Findings:
Duration/History of illness:	Pre Existing Condition: ☐ Chronic Condition: ☐ Maternity ☐ EDD .... Others (please specify): ....

Provisional / Final Diagnosis: (use ICD codes as appropriate) Sev URTI, Bronchitis, fever, vomiting

Plan of Management/Investigation I/. Vent 29/3 I/. Rouph 30/3	Medication Zinnat at 500 Dolgit at 600

PRE-AUTHORIZATION SECTION (MEDICAL & INVESTIGATION REPORT MUST BE ATTACHED WHERE APPLICABLE)

ANTICIPATED LENGTH OF STAY: .... Days | ANTICIPATED COST:

Member Declaration

I the undersigned hereby certify that all statements & information provided concerning identification & the present illness or injury are TRUE. Furthermore, I authorize and request the Hospital to provide my Insurer / TPA with any information they request in connection with any treatment and/or services provided to me and grant them full access to my medical files.

Signature: ....

Date: 29 March 2016

Medical Service Provider Declaration

I/We hereby certify that ALL information mentioned herein are correct & that the medical services shown on this form were medically indicated & necessary for the management of this case.

Name of Doctor: ....

Signature: ....

Stamp: عيادة د. أسامة فؤاد Dr. Osama Fouad Clinic P.O. Box: 26968 Kingdom of Bahrain مملكة البحرين

Date: 29/3

FOR INSURANCE COMPANY USE ONLY:

☐ Approved ☐ Not Approved Comments: ....

Approval No.: .... Approved Validity: ....

Insurance Officer: Signature: Date: / / REF. No.

CONSULTATION