Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **BIDISHA BALUI SUKESH BALUI**	**Service Date**	**:11-May-2024**
Card No	: **I017-029-118905064-01**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	: **BIDISHA BALUI SUKESH BALUI**	**Doctor's Name**	**:Humaira**
Payer Name	: **ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:
TPA	: **E CARE - Green Network**	**Remarks**	:
Validity	: **01-01-1900** To **30-09-2024**		
Gender	: **Female**		
Date Of Birth	: **30-Dec-1998**		
Patient's Tel No	: **0504859518**		

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 : co running nose dry cough ear pain 2 days oe chest is congested no added sounds vitals stable enlarge tonsills water is coming out frrom right side **Duration:**

Vitals: Temp : 36.9 Bp :105 Pulse :65 Resp :20

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,H92.09 - Otalgia, unspecified ear,R05 - Cough,J30.9 - Allergic rhinitis, unspecified, **Date of Onset** :11/05/2024

Requested Investigations: 0195-107704-0801, CEFTRIAXONE-TABUK IV,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,85652, SEDIMENTATION RATE RBC AUTOMATED,86140, C REACTIVE PROTEIN,96374, THER/PROPH/DIAG INJ IV PUSH,9, Consultation GP **Estimated Cost** :

Prescriptions: 0248-135501-1161 - (DEXTROMETHORPHAN : 125 MG/100ML) (DIPHENHYDRAMINE : 100 MG/100ML) (EPHEDRINE : 150 MG/100 ML) (GUAIFENESIN : 10 MG/ML) SYRUP,0005-107001-0052 - (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,0139-116206-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) 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 : Humaira

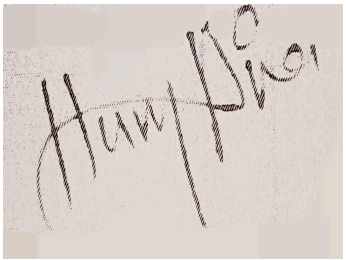
Stamp :

Dr. Humaira Mumtaz
General Practitioner
DHA No: 54155530-002
PESHAWAR MEDICAL CENTER LLC
DUBAI - U.A.E.

Patient 's signature{Parent if minor} :

Date : 11-May-2024

Signature :



Date : 11-May-2024