

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name

: MYO THET TUN

Card No

: I017-029-120534165-01

Policy Holder

: MYO THET TUN

Payer Name

: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC

TPA

: E CARE - Green Network

Validity

: 01-10-2023 To 30-09-2024

Gender

: Male

Date Of Birth

: 02-Dec-1999

Patient's Tel No

: 0558818406

Service Date

:13-May-2024

Health Provider

:Irham Medical Center Arjan

Doctor's Name

:Humaira

Co-Insurance

Remarks

:

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 throat pain dry cough fever running nose 2 days oe chest is congested no added sounds vitals stable

Duration:

Vitals:Temp : 37.2 Bp :134 Pulse :80 Resp :18

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,R50.9 - Fever, unspecified,J30.9 - Allergic rhinitis, unspecified,

Date of Onset

:13/30/2024

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

Estimated : Cost

Prescriptions: 6445-533801-1561 - (ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) DELAYED RELEASE CAPSULES,0097-393801-2471 - (AMMONIUM CHLORIDE : 131.5 MG/5 ML) (DIPHENHYDRAMINE HCL : 13.5 MG/5ML) SYRUP (ALCOHOL FREE),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.

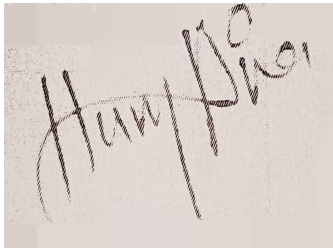
Dr's Name

: Humaira

Stamp :

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

Signature :

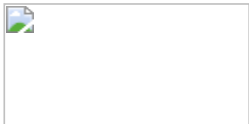


Date

: 13-May-2024

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.

Patient 's signature{Parent : if minor}



13-
Date : May-
2024

https://irhamc.visionsoftwares.ae/mr_ecare_claim_print.aspx?appId=48186&patId=53151

1/1