Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **DEVIPRASAD BANTAKALLU RAI JAYARAMA RAI**	**Service Date**	**:15-May-2024**	**Network**	**:** Green
Card No	: **I017-029-119544825-01**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	: **DEVIPRASAD BANTAKALLU RAI JAYARAMA RAI**	**Doctor's Name**	**:Enomen Goodluck**		
Payer Name	: **ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:		
TPA	: **E CARE - Green Network**	**Remarks**	:		
Validity	: **01-10-2023** To **30-09-2024**				
Gender	: **Male**				
Date Of Birth	: **11-Apr-1988**				
Patient's Tel No	: **0551872973**				

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 : Cough productive of greenish colour phleg since the past 3 days. Also has nasal congestion with pain on the right cheek and just under the eyes **Duration:**

Vitals: Temp : 36.9 Bp :139 Pulse :91 Resp :18

Clinical Findings:

Diagnosis: J01.00 - Acute maxillary sinusitis, unspecified,J22 - Unspecified acute lower respiratory infection,R09.81 - Nasal congestion,R05 - Cough, **Date of Onset** :15/04/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0027-128802-2021 - (XYLOMETAZOLINE HYDROCHLORIDE : 0.1%) NASAL DROPS,0005-116801-1161 - (SODIUM CITRATE : 57 MG/5ML) (AMMONIUM CHLORIDE : 131.5 MG/5 ML) (MENTHOL : 1.1 MG/5 ML) (DIPHENHYDRAMINE : 13.5 MG/5ML) SYRUP,4874-125821-3801 - (POVIDONE IODINE : 0.45%) SPRAY SOLUTION,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,1516-107902-1171 - (IBUPROFEN : 400 MG) TABLETS,0325-143602-1171 - (CEFUROXIME : 500 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 : Enomen Goodluck **Stamp :**

Dr. Enomen Goodluck Ekata
General Practitioner
DHA No: 28040827-001
PESHAWAR MEDICAL CENTER LLC
DUBAI : U.A.E.

Signature : **Date** : 15-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} : **Date :** 15-May-2024