Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **RAMI SAMIR KAMAL ABDELAZIZ**	**Service Date**	**:17-May-2024**
Card No	: **I017-029-116591803-02**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	: **RAMI SAMIR KAMAL ABDELAZIZ**	**Doctor's Name**	**:Humaira**
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	: **22-Jan-1985**		
Patient's Tel No	: **971566442706**		

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 pain in throat fever urination frequently every hour too much 6 days oe chest is clear no addded sounds no abdominal pain enlarge tonsils **Duration:**

Vitals: Temp : 37.8 Bp :119 Pulse :108 Resp :18

Clinical Findings:

Diagnosis: N39.0 - Urinary tract infection, site not specified,R35.0 - Frequency of micturition,J03.90 - Acute tonsillitis, unspecified,E86.0 - Dehydration, **Date of Onset** :17/20/2024

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,80069, RENAL FUNCTION PANEL,81001, URNLS DIP STICK/TABLET REAGENT AUTO MICROSCOPY,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,82947, GLUCOSE QUANTITATIVE BLOOD XCPT REAGENT STRIP,96365, THER/PROPH/DIAG IV INF INIT,96374, THER/PROPH/DIAG INJ IV PUSH,9, Consultation GP **Estimated Cost** :

Prescriptions: 0005-107001-0051 - (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS,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.

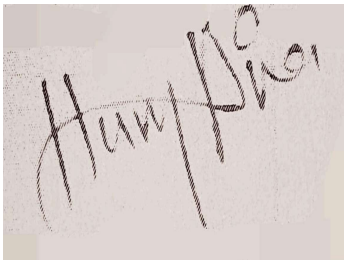
Dr's Name : Humaira

Stamp :

Patient 's signature{Parent if minor} :

Date : 17-May-2024

Signature :



Date : 17-May-2024