Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: Bapan Das**	**Service Date**	**:23-May-2024**
Card No	**: I017-029-116136821-02**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	**: Bapan Das**	**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	**: 17-May-1987**		
Patient's Tel No	**: 0509376802**		

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 cough fever bodyache joint pain on and off heart burn 1 month oe enlarge tonsillls chest is congested no addded sounds small joints pain vitals stable history of smoking **Duration:**

Vitals: Temp : 36.6 Bp :107 Pulse :79 Resp :18

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,M25.579 - Pain in unspecified ankle and joints of unspecified foot,R05 - Cough,R50.9 - Fever, unspecified,K29.70 - Gastritis, unspecified, without bleeding, **Date of Onset** :23/07/2024

Requested Investigations: 0195-107704-0801, CEFTRIAXONE-TABUK IV-(CEFTRIAXONE : 1 G) POWDER FOR INJECTION,96374, THER/PROPH/DIAG INJ IV PUSH,84550, URIC ACID BLOOD,101, GENARAL WELNES CHECKUP (55 TEST),9, Consultation GP **Estimated Cost** :

Prescriptions: 0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,0097-393801-2471 - (AMMONIUM CHLORIDE : 131.5 MG/5 ML) (DIPHENHYDRAMINE HCL : 13.5 MG/5ML) SYRUP (ALCOHOL FREE),0005-119803-1172 - (PREDNISOLONE : 20 MG) TABLETS,0207-533801-1451 - (ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) CAPSULES (HARD GELATIN),0097-127405-0392 - (AZITHROMYCIN : 500 MG) FILM COATED 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

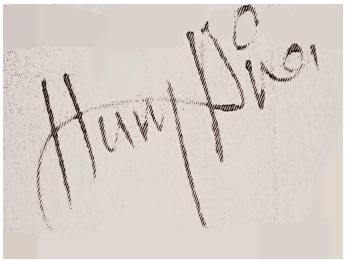
Stamp :

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

Patient 's signature{Parent if minor} :

Date : 23-May-2024

Signature :



Date : 23-May-2024