Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **KUBER POORAN SINGH POORAN MATHURA SINGH**	**Service Date**	**:29-May-2024**
Card No	: **I017-029-119183952-01**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	: **KUBER POORAN SINGH POORAN MATHURA SINGH**	**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	: **20-May-1996**		
Patient's Tel No	: **0555564196**		

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 : Symptoms: Pain in throat, fever, generalized body weakness, nasal congestion and nasal discharge. Duration of onset: 27/05/2024 (3days). Past medical history: Not significant Family history: Not significant Suspected aetiology: viral with secondary bacterial superimposition. General Exam findings: Febrile at 38.6degrees, acutely ill-looking. ENT: Inflamed and hypertrophied tonsils. **Duration:**

Vitals: Temp : 38.6 Bp :120 Pulse :0 Resp :20

Clinical Findings:

Diagnosis: J02.9 - Acute pharyngitis, unspecified,J30.9 - Allergic rhinitis, unspecified,R50.9 - Fever, unspecified, **Date of Onset :**29/52/2024

Requested Investigations: 96365, THER/PROPH/DIAG IV INF INIT,0195-107704-0801, CEFTRIAXONE-TABUK IV,0005-149902-1021, CLOFEN ,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,0005-111805-1021, CHLOROHISTOL 10MG,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,9, Consultation GP,96372, THER/PROPH/DIAG INJ SC/IM **Estimated Cost :**

Prescriptions: 0252-185801-0391 - (DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 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 : Enomen Goodluck

Stamp :

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

Patient 's signature{Parent if minor} :

Date : 29-May-2024

Signature :

Date : 29-May-2024