Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: SHAKEEL MUKHTYAR THANGE THANGE MUKHTYAR MOHAMMAD	**Service Date**	:07-Jun-2024
Card No	: I017-029-119448916-01	**Health Provider**	:Irham Medical Center Arjan
Policy Holder	: SHAKEEL MUKHTYAR THANGE THANGE MUKHTYAR MOHAMMAD	**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	: 29-Sep-1986		
Patient's Tel No	: 0507029989		

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 fever pain in throat 2days oe enlarge tonsills inflamed chest is clear no added sounds **Duration:**

Vitals: Temp : 39.4 Bp :100 Pulse :94 Resp :18

Clinical Findings:

Diagnosis: J03.90 - Acute tonsillitis, unspecified,R50.9 - Fever, unspecified,R52 - Pain, unspecified, **Date of Onset** :07/44/2024

Requested Investigations: 9, Consultation GP,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,85652, SEDIMENTATION RATE RBC AUTOMATED,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,0195-107704-0801, CEFTRIAXONE-TABUK IV,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,96372, THER/PROPH/DIAG INJ SC/IM,96365, THER/PROPH/DIAG IV INF INIT,0102-100104-1001, SODIUM CHLORIDE & DEXTROSE B.P.,96360, HYDRATION IV INFUSION INIT,96374, THER/PROPH/DIAG INJ IV PUSH **Estimated Cost** :

Prescriptions: 0005-107001-0051 - (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS,0067-116604-0391 - (METRONIDAZOLE : 500 MG) FILM COATED TABLETS,0009-143602-1171 - (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.

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

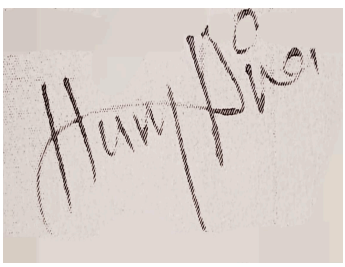
Stamp :

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

Patient 's signature{Parent : if minor}

Date : 07-Jun-2024

Signature :



Date : 07-Jun-2024