

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name

: NYOMAN SUMERINI

Card No

: I017-029-116122287-02

Policy Holder

: NYOMAN SUMERINI

Payer Name

: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC

TPA

: E CARE - Green Network

Validity

: 01-01-1900 To 30-09-2024

Gender

: Female

Date Of Birth

: 13-Sep-1972

Patient's Tel No

: 0509974194

Service Date

:11-Jun-2024

Health Provider

:Irham Medical Center Arjan

Doctor's Name

:Humaira

Co-Insurance

Network

: Green

Direct Access SP

: YES

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

Remarks

:

☐ Acute

☐ Pre-existing and chronic

☐ Maternity

Chief Complaints

: co fever bodyache dry cough running nose pain in throat 3 days oe inflamed and enlarge tonsills chest is congested no added sounds restless

Vitals

:Temp : 37 Bp :110 Pulse :84 Resp :18

Clinical Findings

Diagnosis

: R50.9 - Fever, unspecified,J06.9 - Acute upper respiratory infection, unspecified,J03.90 - Acute tonsillitis, unspecified,R05 - Cough,

Requested Investigations

: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,85652, SEDIMENTATION RATE RBC AUTOMATED,0195-107704-0801, CEFTRIAXONE-TABUK IV,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,96365, THER/PROPH/DIAG IV INF INIT,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP,96374, THER/PROPH/DIAG INJ IV PUSH

Prescriptions

: 0097-393801-2471 - (AMMONIUM CHLORIDE : 131.5 MG/5 ML) (DIPHENHYDRAMINE HCL : 13.5 MG/5ML) SYRUP (ALCOHOL FREE),0195-116604-0391 - (METRONIDAZOLE : 500 MG) FILM COATED TABLETS,0005-107001-0051 - (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,0139-116206-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS,

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

: Humaira

Stamp

Signature

Date

: 11-Jun-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

: 11-Jun-2024