

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : SAHIL AHMAD RAIS AHMAD

Card No : I017-029-113767022-02

Policy Holder : SAHIL AHMAD RAIS AHMAD

Payer Name : ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC

TPA : E CARE - Green Network

Validity : 01-10-2023 To 30-09-2024

Gender : Male

Date Of Birth : 01-Jan-1985

Patient's Tel No : 557208107

Service Date :11-Jun-2024

Health Provider :Irham Medical Center Arjan

Doctor's Name :Humaira

Co-Insurance :

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

Remarks :

Network : Green

Direct Access SP - YES

☐ Acute

☐ Pre-existing and chronic

☐ Maternity

Chief Complaints : co fever on and off body ache cold pain in throat 3 days oe enlarge tonsills

Duration:

chest is clear no added sounds restless

Vitals:Temp : 36.2 Bp :80 Pulse :76 Resp :18

Clinical Findings:

Diagnosis: R50.9 - Fever, unspecified,R52 - Pain, unspecified,J03.90 - Acute tonsillitis, unspecified,

Date of Onset :11/52/2024

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIRNTL WBC COUNT,86140, C REACTIVE PROTEIN,85652, SEDIMENTATION RATE RBC AUTOMATED,0195-107704-0801, CEFTRIAXONE-TABUK IV,96365, THER/PROPH/DIAG IV INF INIT,0005-149902-1021, CLOFEN - (DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP

Estimated : Cost

Prescriptions: 0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,0195-116604-0391 - (METRONIDAZOLE : 500 MG) FILM COATED TABLETS,0009-143602-1171 - (CEFUROXIME : 500 MG) TABLETS,0005-107001-0051 - (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS,

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.

Dr's Name : Humaira

Stamp :

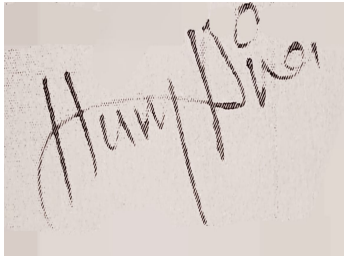
Dr. Humaira Mumtaz

General Practitioner

DHA No: 54155530-002

PESHAWAR MEDICAL CENTER LLC

DUBAI - U.A.E.

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}



11-Jun-2024

Date : Jun-2024