Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **SAYANTAN BARIK MADAN BARIK**	**Service Date**	**:12-Jun-2024**	**Network**	: Green
Card No	: **I017-029-117490451-02**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	: **SAYANTAN BARIK MADAN BARIK**	**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	: **04-Nov-1996**				
Patient's Tel No	: **0502648924**				

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 diarrhea fever on and off 3 days abdominal pain 3 days oe enlarge tonsills **Duration:**
chest is clear no nadded sounds restless having penadol tablet at home smoker

Vitals: Temp : 36.5 Bp :100 Pulse :84 Resp :18

Clinical Findings:

Diagnosis: R19.7 - Diarrhea, unspecified,R10.9 - Unspecified abdominal pain,R05 - Cough,R50.9 - Fever, unspecified, **Date of Onset** :12/56/2024

Requested Investigations: 9, Consultation GP,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,0195-107704-0801, CEFTRIAXONE-TABUK IV,96365, THER/PROPH/DIAG IV INF INIT,96374, THER/PROPH/DIAG INJ IV PUSH,0002-116601-1001, METRONIDAZOLE : 500 MG/100ML) SOLUTION FOR INFUSION ,96365, IV INFUSION THERAPY -Antibiotics & Others,85652, SEDIMENTATION RATE RBC AUTOMATED,86140, C REACTIVE PROTEIN **Estimated Cost** :

Prescriptions: 0102-230603-0831 - (ORAL REHYDRATION SALTS (O.R.S.) : N/A) POWDER FOR SOLUTION,0005-107001-0051 - (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS,0195-116604-0391 - (METRONIDAZOLE : 500 MG) FILM COATED TABLETS,3114-482003-0391 - (CIPROFLOXACIN (AS HYDROCHLORIDE) : 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

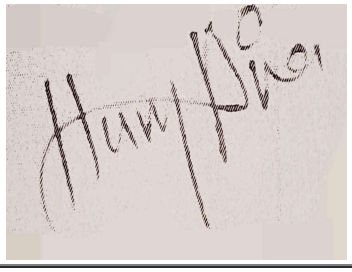
Stamp :

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

Patient 's signature{Parent if minor} :

Date : 12-Jun-2024

Signature :



Date : 12-Jun-2024