Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: SAWARAN CHAND	**Service Date**	:19-Jun-2024	**Network**	: Green
Card No	: I017-029-117490735-02	**Health Provider**	:Irham Medical Center Arjan		**Direct Access SP - YES**
Policy Holder	: SAWARAN CHAND	**Doctor's Name**	:Humaira		
Payer Name	: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC	**Co-Insurance**	:		

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

TPA	: E CARE - Green Network	**Remarks**	:
Validity	: 01-10-2023 To 30-09-2024		
Gender	: Female		
Date Of Birth	: 01-Aug-1996		
Patient's Tel No	: 0589522956		

☐ **Acute** ☐ **Pre-existing and chronic** ☐ **Maternity**

Chief Complaints : co fever throat pain ear pain left side headache bodyache 16 june 2024 oe inflamed and enlarge tonsills chest is clear no added sounds restless **Duration:**

Vitals: Temp : 38 Bp :103 Pulse :95 Resp :18

Clinical Findings:

Diagnosis: J03.90 - Acute tonsillitis, unspecified,R50.9 - Fever, unspecified,R52 - Pain, unspecified,R05 - Cough,H66.90 - Otitis media, unspecified, unspecified ear, **Date of Onset** :19/08/2024

Requested Investigations: 9, Consultation GP,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,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,96365, THER/PROPH/DIAG IV INF INIT,96372, THER/PROPH/DIAG INJ SC/IM **Estimated Cost** :

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,0333-143602-1171 - (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.

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.

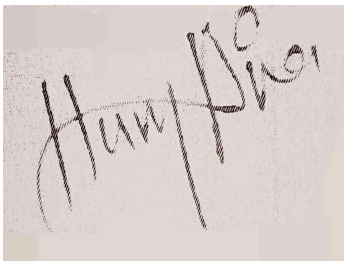
Dr's Name : Humaira

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 : 19-Jun-2024

Signature : 

Date : 19-Jun-2024