Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **SHUBHAM RAVINDRA PANDIT**	**Service Date**	**:20-Jun-2024**
Card No	: **I017-029-120796696-01**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	: **SHUBHAM RAVINDRA PANDIT**	**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	: **18-Aug-1997**		
Patient's Tel No	: **0543199105**		

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 : o fever on and off cough prulantburning in urine pain in the lower abdominal region dark colour urine 4 days oe chest is congested no added sounds restless smoker alcohal only for events co fever on and off cough prulant co fever on and off cough prulant **Duration:**

Vitals:

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,N39.0 - Urinary tract infection, site not specified,R50.9 - Fever, unspecified,R10.30 - Lower abdominal pain, unspecified,R05 - Cough, **Date of Onset** :20/29/2024

Requested Investigations: 9.01, Follow Up Consultation GP,0195-107704-0801, CEFTRIAXONE-TABUK IV,96365, THER/PROPH/DIAG IV INF INIT,30042033, CIPROFLOXACIN,0002-116601-1001, METRONIDAZOLE : 500 MG/100ML) SOLUTION FOR INFUSION **Estimated Cost** :

Prescriptions: **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

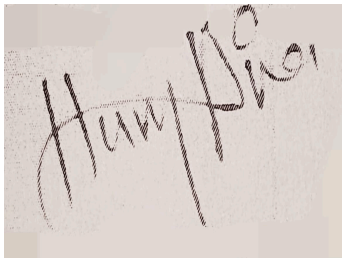
Stamp :

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

Patient 's signature{Parent if minor} :

Date : 20-Jun-2024

Signature :



Date : 20-Jun-2024