

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : HYDERALI ALLABAX
DUKANDAR

Card No : I017-029-116122248-02

Policy Holder : HYDERALI ALLABAX
DUKANDAR

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 : 24-Dec-1989

Patient's Tel No : 0552906380

Service Date : 21-Oct-2023

Network : Green

Health Provider : Irham Medical Center Arjan

Direct Access SP - YES

Doctor's Name : Sajid Sanaullah

Co-Insurance :

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 : follow up case of Fever High grade fever persist CRP 15 Throat pain Chills Duration:
O/E throat congested

Vitals:

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified, J02.9 - Acute pharyngitis, unspecified, R07.0 - Pain in throat, R50.9 - Fever, unspecified, R53.1 - Weakness, R52 - Pain, unspecified, Date of Onset : 21/05/2023

Requested Investigations: 9.01, Follow Up Consultation GP, 96374, THER/PROPH/DIAG INJ IV PUSH, 0195-107704-0802, CEFTRIAXONE-TABUK IM-(CEFTRIAXONE : 1 G) POWDER FOR INJECTION, 2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION

Estimated :
Cost

Prescriptions: 0005-116801-1161 - (SODIUM CITRATE : 57 MG/5ML) (AMMONIUM CHLORIDE : 131.5 MG/5 ML) (MENTHOL : 1.1 MG/5 ML) (DIPHENHYDRAMINE : 13.5 MG/5ML) SYRUP, 0097-127405-0391 - (AZITHROMYCIN : 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 :

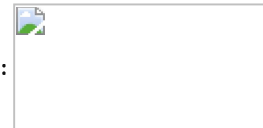
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Sajid Sanaullah

Stamp :



Patient's signature {Parent : if minor}



21-
Date : Oct-
2023

Signature :

Date : 21-Oct-2023