## Administrative

# MEDICAL CLAIM FORM

## Claim Ref:

| | | | |
|---|---|---|---|
| **Patient Name** | : **HYDERALI ALLABAX DUKANDAR** | **Service Date** | **:21-Oct-2023** |
| **Card No** | : **I017-029-116122248-02** | **Health Provider** | **:Irham Medical Center Arjan** |
| **Policy Holder** | : **HYDERALI ALLABAX DUKANDAR** | **Doctor's Name** | **:Sajid Sanaullah** |
| **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** | : **24-Dec-1989** | | |
| **Patient's Tel No** | : **0552906380** | | |

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

**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 :**

Dr. Sajid Sanaullah Khan
General Practitioner
DHA No: 05758224-001
PESHAWAR MEDICAL CENTER LLC
DUBAI - U.A.E.

**Patient 's signature{Parent if minor}** :

**Date** : 21-Oct-2023

**Signature :**

**Date** : 21-Oct-2023