

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : AIPERI NURADILOVA
Card No : I017-029-119448945-01
Policy Holder : AIPERI NURADILOVA
Payer Name : ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC
TPA : E CARE - Blue Network
Validity : 01-10-2023 To 30-09-2024
Gender : Female
Date Of Birth : 13-Nov-1991
Patient's Tel No : 0503569374

Service Date : 21-Oct-2023
Health Provider : Irham Medical Center Arjan
Doctor's Name : Sajid Sanaullah
Co-Insurance :

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

Network : Green
Direct Access SP - YES

Remarks :

☐ Acute
 ☐ Pre-existing and chronic
 ☐ Maternity

Chief Complaints : HIGH FEVER THROAT PAIN BODY PAIN+ RUNNING NOSE PRODUCTIVE COUGH
Duration:

Vitals:Temp : 39.9 Bp :90 Pulse :108 Resp :22

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,R07.0 - Pain in throat,J00 - Acute nasopharyngitis [common cold],R52 - Pain, unspecified,R05 - Cough,R50.9 - Fever, unspecified,
Date of Onset : 21/36/2023

Requested Investigations: 9, Consultation GP,2190-106618-1001, PARAFUSIV I.V. 10MG/ML- (PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,0005-149902-1021, CLOFEN ,2849-100143-0991, 5% W/V DEXTROSE 0.45% & W/V SODIUM CHLORIDE-(DEXTROSE : 5% W/V) (SODIUM CHLORIDE : 0.45% W/V) SOLUTION,0005-111805-1021, CHLOROHISTOL 10MG-(CHLORPHENIRAMINE MALEATE : 10 MG/ML) SOLUTION FOR INJECTION
Estimated Cost :

Prescriptions: 0005-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,2104-242802-0341 - (PANTOPRAZOLE (AS SODIUM) : 40 MG) ENTERIC COATED TABLETS,4884-143701-1451 - (CELECOXIB : 200 MG) CAPSULES (HARD GELATIN),0252-185801-0391 - (DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 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 :

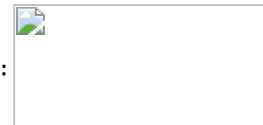
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Sajid Sanaullah

Stamp :



Patient's signature{Parent : if minor}



Date : 21-Oct-2023

Signature :

Date : 21-Oct-2023