Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: AIPERI NURADILOVA**	**Service Date**	**:21-Oct-2023**	**Network**	**: Green**
Card No	**: I017-029-119448945-01**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	**: AIPERI NURADILOVA**	**Doctor's Name**	**:Sajid Sanaullah**		
Payer Name	**: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:		
TPA	**: E CARE - Blue Network**	**Remarks**	:		
Validity	**: 01-10-2023** To **30-09-2024**				
Gender	**: Female**				
Date Of Birth	**: 13-Nov-1991**				
Patient's Tel No	**: 0503569374**				

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 : 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 :**

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