

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : PRINCE AMAR SINGH
Card No : I017-029-118921925-01
Policy Holder : PRINCE AMAR SINGH
Payer Name : ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC
TPA : E CARE - Blue Network
Validity : 01-10-2023 To 30-09-2024
Gender : Male
Date Of Birth : 07-Dec-1992
Patient's Tel No : 0569488659

Service Date : 21-Oct-2023
Health Provider : Irham Medical Center Arjan
Doctor's Name : Enomen Goodluck
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 : Fever since yesterday, Dry cough, and nasal congestion. Temperature today is 38degree

Vitals:Temp : 38 Bp :110 Pulse :100 Resp :24

Clinical Findings:

Diagnosis: J00 - Acute nasopharyngitis [common cold],R05 - Cough,R50.9 - Fever, unspecified,R09.81 - Nasal congestion,
 Date of Onset : 21/13/2023

Requested Investigations: 0005-149902-1021, CLOFEN ,96365, THER/PROPH/DIAG IV INF INIT,85025, **Estimated Cost** :
 BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,0005-111805-1021, CHLOROHISTOL INJECTION,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION

Prescriptions: 5253-649501-3851 - (MOMETASONE FUROATE (AS MONOHYDRATE) : 50 MCG/DOSE) **Estimated Cost** :
 NASAL SPRAY,0005-114501-2481 - (AMBROXOL : 15 MG/5ML) SYRUP (SUGAR FREE),1541-290302-0391 - (LEVOCETIRIZINE (DIHCL OR HCL) : 5MG) FILM COATED TABLETS,0696-107902-0392 - (IBUPROFEN : 400 MG) FILM COATED TABLETS,0252-185801-0391 - (DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS,

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 :

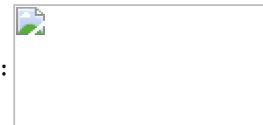
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Enomen Goodluck

Stamp :



Patient's signature{Parent : if minor}



21-
Date : Oct-2023

Signature :

Date : 21-Oct-2023