Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: PRINCE AMAR SINGH**	**Service Date**	**:21-Oct-2023**	**Network**	**: Green**
Card No	**: I017-029-118921925-01**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	**: PRINCE AMAR SINGH**	**Doctor's Name**	**:Enomen Goodluck**		
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	**: Male**				
Date Of Birth	**: 07-Dec-1992**				
Patient's Tel No	**: 0569488659**				

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 : Fever since yesterday, Dry cough, and nasal congestion. Temperature today is 38degree **Duration:**

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, 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 **Estimated Cost** :

Prescriptions: 5253-649501-3851 - (MOMETASONE FUROATE (AS MONOHYDRATE) : 50 MCG/DOSE) 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, **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 : Enomen Goodluck **Stamp :**

Dr. Enomen Goodluck Ekata
General Practitioner
DHA No: 28040827-001
PESHAWAR MEDICAL CENTER LLC
DUBAI - U.A.E.

Patient 's signature{Parent if minor} : **Date** : 21-Oct-2023

Signature : **Date** : 21-Oct-2023