Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **PRIYA SAHU ARUN KUMAR SAHU**	**Service Date**	**:22-Oct-2023**	**Network**	: Green
Card No	: **I017-029-118997977-01**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	: **PRIYA SAHU ARUN KUMAR SAHU**	**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	: **Female**				
Date Of Birth	: **13-Sep-1997**				
Patient's Tel No	: **0582353540**				

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 Fever persist Cough with phlegm Asthmatic, sneezing, runny nose Burning urination on inhaler O/E throat normal, Wheezing present **Duration:**

Vitals: Temp : 38.2 Bp :110 Pulse :106 Resp :24

Clinical Findings:

Diagnosis: J20.9 - Acute bronchitis, unspecified,J45.991 - Cough variant asthma,R52 - Pain, unspecified,R05 - Cough,R50.9 - Fever, unspecified,N39.0 - Urinary tract infection, site not specified,R06.7 - Sneezing,J00 - Acute nasopharyngitis [common cold], **Date of Onset** :22/38/2023

Requested Investigations: 96372, THER/PROPH/DIAG INJ SC/IM,0005-111805-1021, CHLOROHISTOL 10MG-(CHLORPHENIRAMINE MALEATE : 10 MG/ML) SOLUTION FOR INJECTION,96365, THER/PROPH/DIAG IV INF INIT,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,0188-135906-2441, PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION,0006-124513-2071, VENTOLIN NEBULES,94640, AIRWAY INHALATION TREATMENT **Estimated Cost** :

Prescriptions: 1401-395404-0391 - (MONTELUKAST (AS SODIUM) : 10 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 :** 22-Oct-2023

Signature :  **Date** : 22-Oct-2023