Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: RENI YUNITA SARI**	**Service Date**	**:23-Oct-2023**
Card No	**: I017-029-117566015-02**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	**: RENI YUNITA SARI**	**Doctor's Name**	**:Sajid Sanaullah**
Payer Name	**: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	**:**
TPA	**: E CARE - Green Network**	**Remarks**	**:**
Validity	**: 01-10-2022** To **30-10-2023**		
Gender	**: Female**		
Date Of Birth	**: 29-Jun-1994**		
Patient's Tel No	**: 971566442706**		

Network : Green

Direct Access SP - YES

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 : C/o cough , runny nose, blocked nose, fever no allergy redness and swelling on index and middle finger on right hand for 2 weeks Difficulty in breathing O/E wheezing occ **Duration:**

Vitals: Temp : 38.1 Bp :135 Pulse :98 Resp :22

Clinical Findings:

Diagnosis: J02.9 - Acute pharyngitis, unspecified,J00 - Acute nasopharyngitis [common cold],R50.9 - Fever, unspecified,R05 - Cough,A49.9 - Bacterial infection, unspecified,L08.9 - Local infection of the skin and subcutaneous tissue, unsp,R52 - Pain, unspecified, **Date of Onset** :23/52/2023

Requested Investigations: 0188-135906-2441, PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION,0006-124513-2071, VENTOLIN NEBULES,94640, AIRWAY INHALATION TREATMENT,9, Consultation GP **Estimated Cost** :

Prescriptions: 0005-709601-0651 - (GRAMICIDIN : 0.25MG/G) (NEOMYCIN SULPHATE : 2.5 MG/G) (NYSTATIN : 100000 IU/G) (TRIAMCINOLONE ACETONIDE : 1 MG/G) OINTMENT,0067-106705-0053 - (CHLORPHENIRAMINE : 2 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) CAPLETS,0027-265802-1161 - (BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V) SYRUP,0102-142201-0391 - (DICLOFENAC POTASSIUM : 50 MG) FILM COATED TABLETS,0046-159501-0341 - (SERRATIOPEPTIDASE : 5 MG) ENTERIC COATED TABLETS,1308-290301-0391 - (LEVOCETIRIZINE (DIHCL OR HCL) : 5 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 : 23-Oct-2023

Signature :

Date : 23-Oct-2023