

## Administrative

## MEDICAL CLAIM FORM

## Claim Ref:

Patient Name : RINSAD ALIYAR  
 Card No : I017-029-117161088-02  
 Policy Holder : RINSAD ALIYAR

Service Date :23-Oct-2023  
 Health Provider :Irham Medical Center Arjan  
 Doctor's Name :Sajid Sanaullah

Network : Green  
 Direct Access SP - YES

Payer Name : ABU DHABI NATIONAL  
 : INSURANCE COMPANY-ADNIC

|              |              |               |        |           |     |           |        |
|--------------|--------------|---------------|--------|-----------|-----|-----------|--------|
| Co-Insurance | CONSULTATION | LAB/RADIOLOGY | PHYSIO | PHARMACY  | IP  | MATERNITY | DENTAL |
|              | 10% max      | NIL           | NIL    | NIL LIMIT | NIL | 10%       | NA     |

TPA : E CARE - Green Network  
 Validity : 01-10-2023 To 30-09-2024

Remarks :

Gender : Male  
 Date Of Birth : 01-Jan-1993  
 Patient's Tel No : 508085914

☐ Acute ☐ Pre-existing and chronic ☐ Maternity

Chief Complaints : C/O Fever, bodyache, throat pain, runny nose, cough for 2 days O/E Throat and nose congested Chest clear Duration:

Vitals:Temp : 36.9 Bp :105 Pulse :82 Resp :20

## Clinical Findings:

Diagnosis: J02.9 - Acute pharyngitis, unspecified,J00 - Acute nasopharyngitis [common cold],R05 - Cough,R50.9 - Fever, unspecified,R52 - Pain, unspecified, Date of Onset :23/47/2023

Requested Investigations: 9, Consultation GP Estimated Cost :

Prescriptions: 0005-143701-0062 - (CELECOXIB : 200 MG) CAPSULES,0027-265802-1161 - (BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V) SYRUP,0067-106705-0053 - (CHLORPHENIRAMINE : Cost 2 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) CAPLETS,0097-127405-0392 - (AZITHROMYCIN : 500 MG) FILM COATED TABLETS, Estimated :

## 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 :

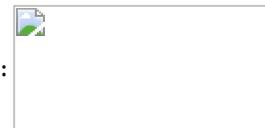
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Sajid Sanaullah

Stamp :



Patient's signature{Parent : if minor}



23-  
Date : Oct-  
2023

Signature :

Date : 23-Oct-2023