

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name

: RAKESH RAWAT KUWAR SINGH

Card No

: I017-029-114504361-02

Policy Holder

: RAKESH RAWAT KUWAR SINGH

Payer Name

: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC

TPA

: E CARE - Green Network

Validity

: 01-10-2023 To 30-09-2024

Gender

: Male

Date Of Birth

: 10-May-1993

Patient's Tel No

: 0569096867

Service Date

: 23-Oct-2023

Health Provider

: Irham Medical Center Arjan

Doctor's Name

: Sajid Sanaullah

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

☐ Acute

☐ Pre-existing and chronic

☐ Maternity

Chief Complaints : C/O Bodyache, cough, Nausea, fever rash and itching over both forearm

Duration :

Vitals:Temp : 36.9 Bp :122 Pulse :82 Resp :20

Clinical Findings:

Diagnosis: J02.9 - Acute pharyngitis, unspecified,L29.9 - Pruritus, unspecified,L23.89 - Allergic contact dermatitis due to other agents,R05 - Cough,R50.9 - Fever, unspecified,

Date of Onset : 23/39/2023

Requested Investigations: 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,0097-127405-0392 - (AZITHROMYCIN : 500 MG) FILM COATED TABLETS,0027-265802-1161 - (BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V) SYRUP,2626-106616-2002 - (PARACETAMOL : 665MG) MODIFIED RELEASE 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.

Dr's Name : Sajid Sanaullah

Stamp :

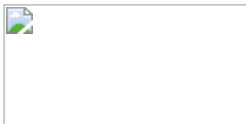
Dr. Sajid Sanaullah Khan
General Practitioner
DHA No: 05758224-001
PESHAWAR MEDICAL CENTER LLC
DUBAI - U.A.E.

Signature :

Date : 23-Oct-2023

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.

Patient 's signature{Parent : if minor}



Date : Oct-2023

https://irhamc.visionsoftw ares.ae/mr_ecare_claim_print.aspx?appld=42228&patId=33145

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