

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : DEVAVRATA VINAYAK TARI
Card No : I017-029-117592795-02
Policy Holder : DEVAVRATA VINAYAK TARI
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 : 21-Mar-1986
Patient's Tel No : 0562812528

Service Date : 24-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

Remarks :

☐ Acute
 ☐ Pre-existing and chronic
 ☐ Maternity

Chief Complaints : c/o pain in throat for 7 days Throat irritation for 21 days No fever O/E throat **Duration:** mild congestion, chest clear

Vitals: Temp : 37.2 Bp :110 Pulse :80 Resp :22

Clinical Findings:

Diagnosis: J02.9 - Acute pharyngitis, unspecified,J03.90 - Acute tonsillitis, unspecified,J45.991 - Cough variant asthma,R07.0 - Pain in throat,
 Date of Onset : 24/52/2023

Requested Investigations: 9, Consultation GP
 Estimated Cost :

Prescriptions: 0195-149907-0612 - (DICLOFENAC SODIUM : 75 MG) MODIFIED RELEASE CAPSULES,0097-127405-0392 - (AZITHROMYCIN : 500 MG) FILM COATED TABLETS,0027-265802-1161 Cost - (BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V) SYRUP,0013-395404-0391 - (MONTELUKAST (AS SODIUM) : 10 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 :

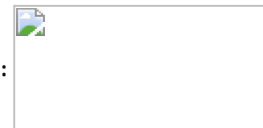
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Sajid Sanaullah

Stamp :



Patient's signature{Parent : if minor}



Date : 24-Oct-2023

Signature :

Date : 24-Oct-2023