Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: ALEXZANDER BRUNO GONSALVES BRUNO GONSALVES**
Card No	**: I017-029-117332687-02**
Policy Holder	**: ALEXZANDER BRUNO GONSALVES BRUNO GONSALVES**
Payer Name	**: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**
TPA	**: E CARE - Green Network**
Validity	**: 01-01-1900** To **30-09-2024**
Gender	**: Male**
Date Of Birth	**: 02-Jan-2000**
Patient's Tel No	**: 0528415188**

Service Date **:25-Oct-2023** **Network** : Green

Health Provider **:Irham Medical Center Arjan** **Direct Access SP - YES**

Doctor's Name **:Sajid Sanaullah**

Co-Insurance :

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

Remarks :

☐ **Acute** ☐ **Pre-existing and chronic** ☐ **Maternity**

Chief Complaints : c/o fever, cough, pain in throat, bodyache, blocked nose since 2 days O/E throat mild congestion, nasal congestion, chest clear No allergy **Duration:**

Vitals: Temp : 37.1 Bp :109 Pulse :92 Resp :22

Clinical Findings:

Diagnosis: J02.9 - Acute pharyngitis, unspecified,J00 - Acute nasopharyngitis [common cold],R50.9 - Fever, unspecified,R05 - Cough,R52 - Pain, unspecified, **Date of Onset** :25/45/2023

Requested Investigations: 9, Consultation GP,96365, THER/PROPH/DIAG IV INF INIT,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,0005-111805-1021, CHLOROHISTOL 10MG-(CHLORPHENIRAMINE MALEATE : 10 MG/ML) SOLUTION FOR INJECTION,96372, THER/PROPH/DIAG INJ SC/IM **Estimated Cost** :

Prescriptions: 0097-127405-0392 - (AZITHROMYCIN : 500 MG) FILM COATED TABLETS,0355-128802-2021 - (XYLOMETAZOLINE HYDROCHLORIDE : 0.1%) NASAL DROPS,1394-143701-1451 - (CELECOXIB : 200 MG) CAPSULES (HARD GELATIN),0252-185801-0391 - (DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS,0005-116801-1161 - (SODIUM CITRATE : 57 MG/5ML) (AMMONIUM CHLORIDE : 131.5 MG/5 ML) (MENTHOL : 1.1 MG/5 ML) (DIPHENHYDRAMINE : 13.5 MG/5ML) SYRUP, **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 : 25-Oct-2023

Signature :

Date : 25-Oct-2023