Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **PANKAJ BAGTI PRABIR KUMAR BAGTI**	**Service Date**	**:25-Oct-2023**	**Network**	: Green
Card No	: **I017-029-116653003-02**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	: **PANKAJ BAGTI PRABIR KUMAR BAGTI**	**Doctor's Name**	**:Sajid Sanaullah**		
Payer Name	: **ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:		
TPA	: **E CARE - Green Network**	**Remarks**	:		
Validity	: **01-01-1900** To **30-09-2024**				
Gender	: **Male**				
Date Of Birth	: **06-Dec-1996**				
Patient's Tel No	: **0544920593**				

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 : O/E throat congested, fever and cough for 1 day bodyache, headache stomach upset, lose stools since morning No allergy **Duration:**

Vitals: Temp : 36.8 Bp :135 Pulse :80 Resp :20

Clinical Findings:

Diagnosis: J03.90 - Acute tonsillitis, unspecified,J02.9 - Acute pharyngitis, unspecified,R52 - Pain, unspecified,R50.9 - Fever, unspecified,R05 - Cough, **Date of Onset** :25/58/2023

Requested Investigations: 96365, THER/PROPH/DIAG IV INF INIT,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,9, Consultation GP **Estimated Cost** :

Prescriptions: 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,0097-127405-0392 - (AZITHROMYCIN : 500 MG) FILM COATED TABLETS,6334-125821-3341 - (POVIDONE IODINE : 0.45%) SOLUTION FOR SPRAY, **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