

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : PANKAJ BAGTI PRABIR KUMAR BAGTI

Card No : I017-029-116653003-02

Policy Holder : PANKAJ BAGTI PRABIR KUMAR BAGTI

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 : 06-Dec-1996

Patient's Tel No : 0544920593

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 : O/E throat congested, fever and cough for 1 day bodyache, headache stomach upset, loose 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 :

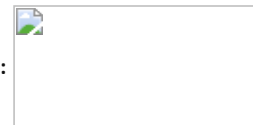
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Sajid Sanaullah

Stamp :



Patient's signature {Parent : if minor}



Date : 25-Oct-2023

Signature :

Date : 25-Oct-2023