

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : SHUBHAM RAJENDRA
 : MENGANE RAJENDRA
 DASHRATH MENGANE
Card No : I017-029-117827723-02
Policy Holder : SHUBHAM RAJENDRA
 : MENGANE RAJENDRA
 DASHRATH MENGANE
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 : 23-Oct-1998
Patient's Tel No : 0506485076

Service Date : 25-Oct-2023
Health Provider : Irham Medical Center Arjan
Doctor's Name : Sajid Sanaullah
Co-Insurance :

Network : Green

Direct Access SP - YES

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 : Severe body pain and high fever since two days ago and on 22/10/2023 and **Duration:** now severe cough and fever and headache and wheezing and cough started

Vitals:

Clinical Findings:

Diagnosis: J18.0 - Bronchopneumonia, unspecified organism, J02.9 - Acute pharyngitis, unspecified, J04.0 - Acute laryngitis, R50.9 - Fever, unspecified, R68.83 - Chills (without fever),
 Date of Onset : 25/28/2023

Requested Investigations: 9.01, Follow Up Consultation GP, 2849-100143-0991, 5% W/V DEXTROSE 0.45% & W/V SODIUM CHLORIDE, 0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE, 0005-149902-1021, CLOFEN, 0195-107704-0802, CEFTRIAXONE-TABUK IM, 0005-111805-1021, CHLOROHISTOL 10MG, 96360, HYDRATION IV INFUSION INIT, 96374, THER/PROPH/DIAG INJ IV PUSH, 94640, AIRWAY INHALATION TREATMENT, 0188-135906-2441, PULMICORT, 0006-124513-2071, VENTOLIN NEBULES
 Estimated : Cost

Prescriptions: 0006-402804-2481 - (SALBUTAMOL(AS SULPHATE) : 2 MG/5ML) SYRUP (SUGAR FREE), 0788-106705-1171 - (CHLORPHENIRAMINE MALEATE : 2 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) TABLETS, 0139-116206-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) 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.

PATIENT'S DECLARATION :

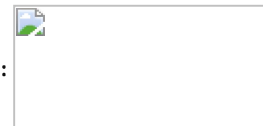
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Sajid Sanaullah

Stamp :



Patient's signature{Parent : if minor}



Date : 25-Oct-2023

Signature :

Date : 25-Oct-2023