

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : KHARAK SINGH KISHAN SINGH

Card No : I017-029-119076401-01

Policy Holder : KHARAK SINGH KISHAN SINGH

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 : 15-Jul-1998

Patient's Tel No : 0569469783

Service Date : 26-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 : Follow up case, no relief in cough, feverish, nausea, bodyache, runny nose
Symptoms started on 16 october Difficulty breathing while coughing Throat NAD, Nose congested Chest b/l air entry equal

Vitals:Temp : 36.7 Bp :105 Pulse :82 Resp :22

Clinical Findings:

Diagnosis: J20.9 - Acute bronchitis, unspecified,J06.9 - Acute upper respiratory infection, unspecified,J00 - Acute nasopharyngitis [common cold],R05 - Cough,R50.9 - Fever, unspecified,R52 - Pain, unspecified,K29.00 - Acute gastritis without bleeding,
Date of Onset : 26/19/2023

Requested Investigations: 85027, BLOOD COUNT COMPLETE AUTOMATED,86140, C REACTIVE PROTEIN,0188-135906-2441, PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION,0006-124513-2071, VENTOLIN NEBULES,94640, AIRWAY INHALATION TREATMENT,96374, THER/PROPH/DIAG INJ IV PUSH,0005-242802-0781, PANTONIX 40MG I.V.- (PANTOPRAZOLE (AS SODIUM) : 40 MG) POWDER FOR INFUSION,9.01, Follow Up Consultation GP

Estimated : Cost

Prescriptions: 0097-116207-0391 - (AMOXICILLIN : 500 MG) (CLAVULANIC ACID : 125 MG) FILM COATED TABLETS,0137-242802-0341 - (PANTOPRAZOLE (AS SODIUM) : 40 MG) ENTERIC COATED 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 :

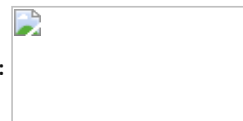
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Sajid Sanaullah

Stamp :



Patient's signature{Parent : if minor}



Date : Oct-2023

Signature :

Date : 26-Oct-2023