Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **KHARAK SINGH KISHAN SINGH**	**Service Date**	**:26-Oct-2023**	**Network**	: Green
Card No	: **I017-029-119076401-01**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	: **KHARAK SINGH KISHAN SINGH**	**Doctor's Name**	**:Sajid Sanaullah**		
Payer Name	: **ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:		
TPA	: **E CARE - Green Network**	**Remarks**	:		
Validity	: **01-10-2023** To **30-09-2024**				
Gender	: **Male**				
Date Of Birth	: **15-Jul-1998**				
Patient's Tel No	: **0569469783**				

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 : 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 **Duration:**

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 : 26-Oct-2023

Signature :

Date : 26-Oct-2023