

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : ASHIKA RAJENDRA SHEJWAL
Card No : I017-029-117827726-02
Policy Holder : ASHIKA RAJENDRA SHEJWAL
Payer Name : ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC
TPA : E CARE - Green Network
Validity : 01-10-2023 To 30-09-2024
Gender : Female
Date Of Birth : 16-Mar-1996
Patient's Tel No : 0504581604

Service Date : 26-Oct-2023
Health Provider : Irham Medical Center Arjan
Doctor's Name : Sajid Sanaullah
Co-Insurance :

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

Network : Green
Direct Access SP - YES

Remarks :

☐ Acute
 ☐ Pre-existing and chronic
 ☐ Maternity

Chief Complaints : c/o fever , throat pain , cough, runny nose , blocked nose since 2 days O/E **Duration:**

Throat NAD Chest bilateral air entry equal, wheezing +

Vitals: Temp : 38.1 Bp :100 Pulse :96 Resp :24

Clinical Findings:

Diagnosis: J20.9 - Acute bronchitis, unspecified, J30.9 - Allergic rhinitis, unspecified, R05 - Cough, R50.9 - Fever, unspecified, R06.2 - Wheezing, **Date of Onset** : 26/33/2023

Requested Investigations: 96374, THER/PROPH/DIAG INJ IV PUSH, 2190-106618-1001, PARAFUSIV I.V. **Estimated :**
 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION, 0188-135906-2441, **Cost**
 PULMICORT, 0006-124513-2071, VENTOLIN NEBULES, 94640, AIRWAY INHALATION TREATMENT, 9,
 Consultation GP

Prescriptions: 0252-185801-0391 - (DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) **Estimated :**
 (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS, 0006-106601-0391 - (PARACETAMOL : 500 MG) **Cost**
 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, 0027-
 296201-1971 - (XYLOMETAZOLINE HCL (MENTHOL) : 0.1%) LIQUID FOR SPRAY (NASAL), 0097-127405-
 0392 - (AZITHROMYCIN : 500 MG) FILM COATED TABLETS,

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 :

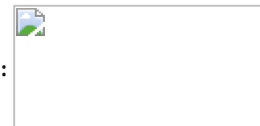
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Sajid Sanaullah

Stamp :



Patient's signature {Parent : if minor}



Date : 26-Oct-2023

Signature :

Date : 26-Oct-2023