Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **MANDAR RAMESH PHANSE RAMESH GOVIND PHANSE**	**Service Date**	**:26-Oct-2023**	**Network**	: Green
Card No	: **I017-029-119020234-01**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	: **MANDAR RAMESH PHANSE RAMESH GOVIND PHANSE**	**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	: **05-May-1997**				
Patient's Tel No	: **0566442706**				

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 : c/o throat pain since 2 days Cough with phlegm, runny nose, O/E thraot cogested Chest wheezing+ **Duration:**

Vitals: Temp : 36.6 Bp :130 Pulse :78 Resp :22

Clinical Findings:

Diagnosis: J20.9 - Acute bronchitis, unspecified,J30.9 - Allergic rhinitis, unspecified,J02.9 - Acute pharyngitis, unspecified,R07.0 - Pain in throat,R05 - Cough, **Date of Onset** :26/48/2023

Requested Investigations: 94640, AIRWAY INHALATION TREATMENT,0188-135906-2441, PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION,0006-124513-2071, VENTOLIN NEBULES,9, Consultation GP **Estimated Cost** :

Prescriptions: 0195-149907-0612 - (DICLOFENAC SODIUM : 75 MG) MODIFIED RELEASE CAPSULES,0097-116206-0391 - (AMOXICILLIN : 875 MG) (CLAVULANIC ACID : 125 MG) FILM COATED TABLETS,1308-290301-0391 - (LEVOCETIRIZINE (DIHCL OR HCL) : 5 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, **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