

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : ARAVINDA RUMESH
Service Date : 27-Oct-2023
Network : Green
Health Provider : Irham Medical Center Arjan
Direct Access SP - YES
Card No : I017-029-116365659-02
Doctor's Name : Sajid Sanaullah
Policy Holder : ARAVINDA RUMESH
Co-Insurance :

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

Payer Name : ABU DHABI NATIONAL
Insurance Company - ADNIC
TPA : E CARE - Blue Network
Remarks :
Validity : 01-10-2023 To 30-09-2024
Gender : Male
Date Of Birth : 01-Jan-1999
Patient's Tel No : 561023776

☐ Acute
 ☐ Pre-existing and chronic
 ☐ Maternity

Chief Complaints : High fever and severe chills and dry cough and vomiting since yesterday
Duration : 26/10/2023

Vitals: Temp : 36.7 Bp :110 Pulse :78 Resp :22

Clinical Findings:

Diagnosis: J02.9 - Acute pharyngitis, unspecified, R50.9 - Fever, unspecified, R05 - Cough, R11.2 - Nausea with vomiting, Date of Onset : 27/22/2023
 unspecified, J20.9 - Acute bronchitis, unspecified, K29.00 - Acute gastritis without bleeding,

Requested Investigations: 2849-100143-0991, 5% W/V DEXTROSE 0.45% & W/V SODIUM CHLORIDE, 0005-242802-0781, PANTONIX 40MG I.V.-(PANTOPRAZOLE (AS SODIUM) : 40 MG) POWDER
Estimated Cost
 FOR INFUSION, 0248-122107-1021, DEXAMETHASONE SODIUM PHOSPHATE, 0005-150403-1021, PREMOSAN , 0005-149902-1021, CLOFEN , 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, 9, Consultation GP

Prescriptions: 0031-168201-0391 - (DOMPERIDONE : 10 MG) FILM COATED TABLETS, 0006-402804-2481 - (SALBUTAMOL (AS SULPHATE) : 2 MG/5ML) SYRUP (SUGAR FREE), 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 :

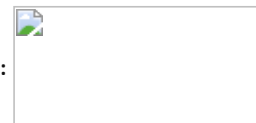
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Sajid Sanaullah

Stamp :



Patient's signature (Parent : if minor)



Date : 27-Oct-2023

Signature :

Date : 27-Oct-2023