Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **SACHIN KANDWAL SUNIL KANDWAL**	**Service Date**	**:27-Oct-2023**
Card No	: **I017-029-118161574-02**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	: **SACHIN KANDWAL SUNIL KANDWAL**	**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	: **23-Oct-1998**		
Patient's Tel No	: **0508826173**		

Network : Green

Direct Access SP - YES

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 : severe cough started five days back with barking type **Duration :**

Vitals: Temp : 37.9 Bp :110 Pulse :96 Resp :24

Clinical Findings:

Diagnosis: J18.0 - Bronchopneumonia, unspecified organism,R06.2 - Wheezing, **Date of Onset** :27/50/2023

Requested Investigations: 94640, AIRWAY INHALATION TREATMENT,0188-135906-2441, PULMICORT,0006-124513-2071, VENTOLIN NEBULES,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,0005-111805-1021, CHLOROHISTOL 10MG,96372, THER/PROPH/DIAG INJ SC/IM,9.01, Follow Up Consultation GP **Estimated Cost** :

Prescriptions: 0015-101502-0271 - (ACETYLCYSTEINE : 600 MG) EFFERVESCENT TABLETS,0006-402802-1391 - (SALBUTAMOL(AS SULPHATE) : 100 MCG/DOSE) AEROSOL INHALER, **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