

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : NIKHIL ROY KOODALI
Card No : I017-029-119828392-01
Policy Holder : NIKHIL ROY KOODALI
Payer Name : ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC
TPA : E CARE - Green Network
Validity : 01-10-2023 To 30-09-2024
Gender : Male
Date Of Birth : 10-Mar-1999
Patient's Tel No : 0521663649

Service Date : 28-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 : severe cough and wheezing for four days started on 25/10/2023 severe sore throat and mild fever

Vitals: Temp : 36.8 Bp :100 Pulse :80 Resp :24

Clinical Findings:

Diagnosis: J02.9 - Acute pharyngitis, unspecified, J20.9 - Acute bronchitis, unspecified, R06.2 - Wheezing, R05 - Cough,
 Date of Onset : 28/20/2023

Requested Investigations: 9, Consultation GP, 0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE, 0005-111805-1021, CHLOROHISTOL 10MG, 96372, THER/PROPH/DIAG INJ SC/IM, 94640, AIRWAY INHALATION TREATMENT, 0006-124513-2071, VENTOLIN NEBULES, 0188-135906-2441, PULMICORT
 Estimated Cost :

Prescriptions: 0097-116206-0391 - (AMOXICILLIN : 875 MG) (CLAVULANIC ACID : 125 MG) FILM 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 :

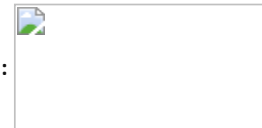
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Sajid Sanaullah

Stamp :



Patient's signature {Parent : if minor}



Date : 28-Oct-2023

Signature :

Date : 28-Oct-2023