

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : Waqas Ahmed Shafiq Ahmed
Card No : I017-029-118526034-02
Policy Holder : Waqas Ahmed Shafiq Ahmed
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 : 28-Apr-1989
Patient's Tel No : 0508203759

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 : High fever and severe cough and wheezing since yesterday 27/10/2023
 severe body pain and chest pain when coughing

Vitals:

Clinical Findings:

Diagnosis: J18.0 - Bronchopneumonia, unspecified organism, J20.9 - Acute bronchitis, unspecified, J02.9 - Acute pharyngitis, unspecified, R05 - Cough, R06.2 - Wheezing,

Date of Onset : 28/05/2023

Requested Investigations: 0102-100104-1001, SODIUM CHLORIDE & DEXTROSE B.P., 0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE, 0005-149902-1021, CLOFEN, 0195-107704-0801, CEFTRIAXONE-TABUK IV, 0005-111805-1021, CHLOROHISTOL 10MG, 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

Estimated : Cost

Prescriptions: 0006-402804-2481 - (SALBUTAMOL(AS SULPHATE) : 2 MG/5ML) SYRUP (SUGAR FREE), 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, 0788-106705-1171 - (CHLORPHENIRAMINE MALEATE : 2 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) TABLETS, 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 :

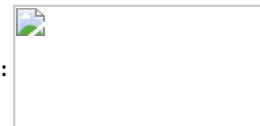
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Sajid Sanaullah

Stamp :



Patient's signature{Parent : if minor}



Date : 28-Oct-2023

Signature :

Date : 28-Oct-2023