

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : MAUREEN WANJIKU MBURU
 Card No : I017-029-116524273-02
 Policy Holder : MAUREEN WANJIKU MBURU

Service Date : 29-Oct-2023
 Health Provider : Irham Medical Center Arjan
 Doctor's Name : Sajid Sanaullah

Network : Green
 Direct Access SP - YES

Payer Name : ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC

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

TPA : E CARE - Green Network
 Validity : 01-10-2023 To 30-09-2024
 Gender : Female
 Date Of Birth : 12-Sep-1986
 Patient's Tel No : 0568181242

Remarks :

☐ Acute ☐ Pre-existing and chronic ☐ Maternity

Chief Complaints : Severe cough and fever since three days started on 25/10/2023 severe running nose and chest pain when coughing also present

Duration:

Vitals:

Clinical Findings:

Diagnosis: J18.0 - Bronchopneumonia, unspecified organism, R50.9 - Fever, unspecified, R06.03 - Acute respiratory distress, R06.2 - Wheezing, R07.1 - Chest pain on breathing, Date of Onset : 29/56/2023

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

Estimated :
Cost

Prescriptions: 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, 0006-402804-2481 - (SALBUTAMOL (AS SULPHATE) : 2 MG/5ML) SYRUP (SUGAR FREE), 0252-185801-0391 - (DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED 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 :

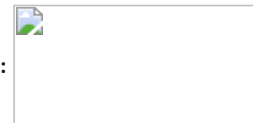
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Sajid Sanaullah

Stamp :



Patient's signature (Parent : if minor)



Date : 29-Oct-2023

Signature :

Date : 29-Oct-2023