Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: YADANAR WIN**	**Service Date**	**:30-Oct-2023**
Card No	**: I017-029-119655330-01**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	**: YADANAR WIN**	**Doctor's Name**	**:Enomen Goodluck**
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	**: Female**		
Date Of Birth	**: 03-May-2002**		
Patient's Tel No	**: 0557536608**		

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 : C/o: Pain in throat, nasal congestion, runny nose, Fever, headache, sneezing and coughing. Also generalized body and joint pains but there is no specific chest pain. Fever started yesterday. **Duration:**

Vitals: Temp : 38.3 Bp :110 Pulse :100 Resp :24

Clinical Findings:

Diagnosis: J00 - Acute nasopharyngitis [common cold],R05 - Cough,R50.9 - Fever, unspecified,R09.81 - Nasal congestion,R06.7 - Sneezing, **Date of Onset** :30/06/2023

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,96365, THER/PROPH/DIAG IV INF INIT,0005-149902-1021, CLOFEN ,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,9, Consultation GP **Estimated Cost** :

Prescriptions: 4874-125821-3801 - (POVIDONE IODINE : 0.45%) SPRAY SOLUTION,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,0005-116801-2481 - (SODIUM CITRATE : 57 MG/5ML) (AMMONIUM CHLORIDE : 131.5 MG/5 ML) (MENTHOL : 1.1 MG/5 ML) (DIPHENHYDRAMINE : 13.5 MG/5ML) SYRUP (SUGAR FREE),0252-185801-0391 - (DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS,0696-107902-0392 - (IBUPROFEN : 400 MG) FILM COATED TABLETS, **Estimated Cost** :

MEDICAL PRACTITIONER DECLARATION :

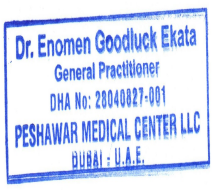
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

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 : Enomen Goodluck

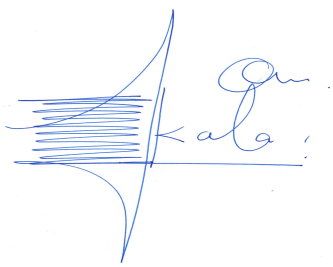
Stamp :



Patient 's signature{Parent if minor} :

Date : 30-Oct-2023

Signature :



Date : 30-Oct-2023