Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: SATHISH PALANI PALANI**	**Service Date**	**:02-Nov-2023**
Card No	**: I017-029-118921928-01**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	**: SATHISH PALANI PALANI**	**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	**: 05-Aug-2000**		
Patient's Tel No	**: 0523200992**		

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 : low BP, dry cough., fever, headache, body pain. **Duration :**

Vitals: Temp : 38.5 Bp :114 Pulse :88 Resp :22

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,R05 - Cough,R52 - Pain, unspecified,R50.9 - Fever, unspecified,E86.0 - Dehydration,I95.9 - Hypotension, unspecified,A41.9 - Sepsis, unspecified organism,A49.9 - Bacterial infection, unspecified,R53.1 - Weakness, **Date of Onset** :02/24/2023

Requested Investigations: 9, Consultation GP,94640, AIRWAY INHALATION TREATMENT,0188-135906-2441, PULMICORT,9, Consultation GP **Estimated Cost** :

Prescriptions: 0188-135906-2441 - (BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION,6774-962101-1003 - (SODIUM LACTATE : 3.2 G/L) (CALCIUM CHLORIDE (AS DIHYDRATE) : 0.27 G/L) (POTASSIUM CHLORIDE : 0.4 G/L) (SODIUM CHLORIDE : 6 G/L) SOLUTION FOR INFUSION,2027-560101-0392 - (IBUPROFEN : 150 MG) (PARACETAMOL : 500 MG) FILM COATED TABLETS,0496-106617-0131 - (PARACETAMOL : 1 G) CONCENTRATE FOR INFUSION,1394-143701-1453 - (CELECOXIB : 200 MG) CAPSULES (HARD GELATIN),6960-116403-0061 - (AMOXICILLIN : 500 MG) CAPSULES,0097-393801-2471 - (AMMONIUM CHLORIDE : 131.5 MG/5 ML) (DIPHENHYDRAMINE HCL : 13.5 MG/5ML) SYRUP (ALCOHOL FREE), **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 : 02-Nov-2023

Signature :

Date : 02-Nov-2023