Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **MAJEED MASIH SARDAR MASIH**	**Service Date**	**:04-Nov-2023**
Card No	: **I017-029-116125749-02**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	: **MAJEED MASIH SARDAR MASIH**	**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	: **Male**		
Date Of Birth	: **03-Jan-1966**		
Patient's Tel No	: **0505140326**		

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

Network : Green

Direct Access SP - YES

☐ **Acute** ☐ **Pre-existing and chronic** ☐ **Maternity**

Chief Complaints : For medication refill. Also C/o Cough productive of greenish sputum. No fever, no chest pain and no difficulty breathing. **Duration:**

Vitals: Temp : 37 Bp :114 Pulse :76 Resp :20

Clinical Findings:

Diagnosis: I10 - Essential (primary) hypertension,E78.2 - Mixed hyperlipidemia,J06.9 - Acute upper respiratory infection, unspecified,J30.9 - Allergic rhinitis, unspecified,R05 - Cough, **Date of Onset** :04/51/2023

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0321-164103-0391 - (METFORMIN HCL : 500 MG) FILM COATED TABLETS,0252-186702-0391 - (LOSARTAN POTASSIUM : 50 MG) (HYDROCHLOROTHIAZIDE : 12.5 MG) FILM COATED TABLETS,2138-386002-0391 - (ATORVASTATIN (AS CALCIUM) : 20 MG) FILM COATED TABLETS,5363-863401-1171 - (PARACETAMOL : 400 MG) (PSEUDOEPHEDRINE HCL : 30 MG) (CAFFEINE : 32 MG) (CHLORPHENIRAMINE MALEATE : 3 MG) TABLETS,0320-148701-1171 - (LORATADINE : 10 MG) TABLETS,0005-119805-1172 - (PREDNISOLONE : 5 MG) TABLETS,5363-393801-1161 - (DIPHENHYDRAMINE HCL : 13.5 MG/5ML) (AMMONIUM CHLORIDE : 131.5 MG/5 ML) SYRUP,

Estimated : Cost

MEDICAL PRACTITIONER DECLARATION :

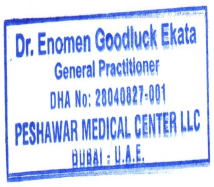
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

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

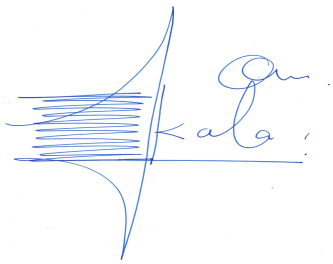
Stamp :



Patient 's signature{Parent : if minor}

Date : 04-Nov-2023

Signature :



Date : 04-Nov-2023