Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: ZUHAYR ALI**	**Service Date**	**:05-Nov-2023**	**Network**	**:** Green
Card No	**: I017-029-116381377-02**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	**: ZUHAYR ALI**	**Doctor's Name**	**:Mohammadmahdi**		
Payer Name	**: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:		
TPA	**: E CARE - Blue Network**	**Remarks**	:		
Validity	**: 26-01-2023** To **25-01-2024**				
Gender	**: Male**				
Date Of Birth	**: 28-Feb-2018**				
Patient's Tel No	**: 0563097844**				

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 : High fever and body pain since three days started on 2/11/2023 severe cough and chest pain also is there **Duration:**

Vitals: Temp : 38 Bp :0 Pulse :110 Resp :24

Clinical Findings:

Diagnosis: J02.9 - Acute pharyngitis, unspecified,J20.9 - Acute bronchitis, unspecified,R50.9 - Fever, unspecified,R05 - Cough,R06.2 - Wheezing,H10.89 - Other conjunctivitis, **Date of Onset** :05/17/2023

Requested Investigations: 10, Consultation Specialist,0195-107704-0802, CEFTRIAXONE-TABUK IM,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,0005-149902-1021, CLOFEN ,96372, THER/PROPH/DIAG INJ SC/IM,94640, AIRWAY INHALATION TREATMENT,0188-135906-2441, PULMICORT,0006-124513-2071, VENTOLIN NEBULES **Estimated Cost** :

Prescriptions: 0085-103204-0371 - (CIPROFLOXACIN : 0.3%) EYE DROPS,1086-123702-1381 - (CETIRIZINE HCL : 1 MG/ML) SOLUTION (ORAL),0139-116204-2151 - (CLAVULANIC ACID : 57 MG/5ML) (AMOXICILLIN : 400 MG/5ML) POWDER FOR 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 :

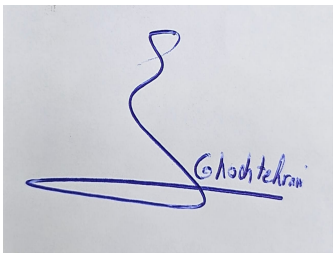
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Mohammadmahdi **Stamp :**

Patient 's signature{Parent if minor} :

Date : 05-Nov-2023

Signature :



Date : 05-Nov-2023