Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **PAPPU RAJAK RAM CHANDRA RAJAK**	**Service Date**	**:06-Nov-2023**
Card No	: **I017-029-116125943-02**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	: **PAPPU RAJAK RAM CHANDRA RAJAK**	**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	: **01-Jan-1987**		
Patient's Tel No	: **555208405**		

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 : Severe nose block and secretions from nose since 1/11/2023 **Duration :**

Vitals: Temp : 37 Bp :100 Pulse :68 Resp :24

Clinical Findings:

Diagnosis: J01.40 - Acute pansinusitis, unspecified,J30.9 - Allergic rhinitis, unspecified,R09.81 - Nasal congestion, **Date of Onset:**06/23/2023

Requested Investigations: 9, Consultation GP,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,0005-111805-1021, CHLOROHISTOL 10MG-(CHLORPHENIRAMINE MALEATE : 10 MG/ML) SOLUTION FOR INJECTION,0195-107704-0802, CEFTRIAXONE-TABUK IM,96372, THER/PROPH/DIAG INJ SC/IM,94640, AIRWAY INHALATION TREATMENT,0188-135906-2441, PULMICORT **Estimated Cost :**

Prescriptions: 0070-124404-2061 - (MOMETASONE FUROATE : 50 MCG) NASAL SPRAY PUMP,2495-119101-1691 - (ANTAZOLINE : 0.5%) (NAPHAZOLINE : 0.025%) EYE / NOSE DROPS (SOLUTION),1401-395404-0391 - (MONTELUKAST (AS SODIUM) : 10 MG) FILM COATED TABLETS,0030-183202-0391 - (FEXOFENADINE HCL : 180 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 : 06-Nov-2023

Signature :

Date : 06-Nov-2023