Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: YAM RAJ GIRI**	**Service Date**	**:07-Nov-2023**	**Network**	**: Green**
Card No	**: I017-029-116653001-02**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	**: YAM RAJ GIRI**	**Doctor's Name**	**:Sajid Sanaullah**		
Payer Name	**: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:		
TPA	**: E CARE - Green Network**	**Remarks**	:		
Validity	**: 01-01-1900** To **30-09-2024**				
Gender	**: Male**				
Date Of Birth	**: 01-Jan-1991**				
Patient's Tel No	**: 54381867448787800**				

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 dry cough, body pain-malaise, runny nose-blocked nose **Duration :**

Vitals: Temp : 37.1 Bp :109 Pulse :90 Resp :22

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,J02.9 - Acute pharyngitis, unspecified,J03.90 - Acute tonsillitis, unspecified,R05 - Cough,R07.0 - Pain in throat,R52 - Pain, unspecified,R53.1 - Weakness,J20.9 - Acute bronchitis, unspecified, **Date of Onset** :07/12/2023

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0067-442001-2481 - (AMBROXOL HCL : 30 MG/5ML) SYRUP (SUGAR FREE),0097-393801-2471 - (AMMONIUM CHLORIDE : 131.5 MG/5 ML) (DIPHENHYDRAMINE HCL : 13.5 MG/5ML) SYRUP (ALCOHOL FREE),0006-106601-0394 - (PARACETAMOL : 500 MG) FILM COATED TABLETS,0027-128802-1971 - (XYLOMETAZOLINE HYDROCHLORIDE : 0.1%) LIQUID FOR SPRAY (NASAL),0097-127405-0392 - (AZITHROMYCIN : 500 MG) FILM COATED TABLETS,4885-107902-0971 - (IBUPROFEN : 400 MG) SOFT GELATIN CAPSULES, **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.

Dr's Name : Sajid Sanaullah **Stamp :**

Signature :

Date : 07-Nov-2023

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.

Patient 's signature{Parent : if minor}

Date : 07-Nov-2023