Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: LEAH MARCELO APOSTOL**	**Service Date**	**:08-Nov-2023**	**Network**	**:** Green
Card No	**: I017-029-116125800-02**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	**: LEAH MARCELO APOSTOL**	**Doctor's Name**	**:Dr.Rashmi Mosale**		
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	**: Female**				
Date Of Birth	**: 06-May-1978**				
Patient's Tel No	**: 0525696874**				

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 : fever cough sorethroat since 2 days productive sputum with blood tinge noted once O/e- alert, afebrile throat congested Known hypertensive on medication RS- rhonchi with fine crackles **Duration:**

Vitals: Temp : 36.8 Bp :130 Pulse :91 Resp :22

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,R05 - Cough,R50.9 - Fever, unspecified,I10 - Essential (primary) hypertension,J20.9 - Acute bronchitis, unspecified, **Date of Onset** :08/07/2023

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0005-124508-1171 - (SALBUTAMOL : 2 MG) TABLETS,0005-134003-1161 - (BROMHEXINE HYDROCHLORIDE : 4 MG/5ML) SYRUP,0252-185801-0391 - (DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS,0097-142201-0391 - (DICLOFENAC POTASSIUM : 50 MG) FILM COATED TABLETS,0252-155401-0391 - (LOSARTAN POTASSIUM : 50 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 : Dr.Rashmi Mosale **Stamp :**

Dr. Rashmi Keshava Murthy Mosale
General Practitioner
DHA No: 00230994-003
PESHAWAR MEDICAL CENTER LLC
DUBAI - U.A.E.

Patient 's signature{Parent : if minor} **Date :** 08-Nov-2023

Signature : **Date** : 08-Nov-2023