

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name

: ROLAND SEBASTIAN DSILVA

Card No

: I017-029-116223049-02

Policy Holder

: ROLAND SEBASTIAN DSILVA

Payer Name

: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC

TPA

: E CARE - Green Network

Validity

: 01-01-1900 To 30-09-2024

Gender

: Male

Date Of Birth

: 14-Jun-1982

Patient's Tel No

: 0505083098

Service Date

: 09-Nov-2023

Health Provider

: Irham Medical Center Arjan

Doctor's Name

: Dr.Rashmi Mosale

Co-Insurance

:

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

Network

: Green

Direct Access SP

: YES

Remarks

:

☐ Acute

☐ Pre-existing and chronic

☐ Maternity

Chief Complaints

: fever cough cold since 2 days generalised body ache present known hypertensive on medication O/e- febrile looks ill tonsils enlarged congested RS- clear Advised CBC, CRP and throat swab Patient refused investigations rest for 2 days

Duration:

Vitals

:Temp : 36.8 Bp :126 Pulse :91 Resp :22

Clinical Findings:

Diagnosis

: J03.90 - Acute tonsillitis, unspecified,J00 - Acute nasopharyngitis [common cold],R05 - Cough,R50.9 - Fever, unspecified,R53.1 - Weakness,

Date of Onset

:09/34/2023

Requested Investigations

: 9, Consultation GP

Estimated Cost

:

Prescriptions

: 0097-116207-0391 - (AMOXICILLIN : 500 MG) (CLAVULANIC ACID : 125 MG) FILM COATED TABLETS,0278-107902-0391 - (IBUPROFEN : 400 MG) FILM COATED TABLETS,0252-185801-0391 - (DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 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.

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.

Signature :



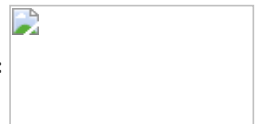
Date

: 09-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

: Nov-2023

https://irhamc.visionsoftw ares.ae/mr_ecare_claim_print.aspx?appld=42892&patId=28017

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