

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : BIDISHA BALUI SUKESH BALUI
Card No : I017-029-118905064-01
Policy Holder : BIDISHA BALUI SUKESH BALUI

Payer Name : ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC

TPA : E CARE - Green Network
Validity : 01-01-1900 To 30-09-2024
Gender : Female
Date Of Birth : 30-Dec-1998
Patient's Tel No : 0504859518

Service Date : 14-Nov-2023
Health Provider : Irham Medical Center Arjan
Doctor's Name : Sajid Sanaullah

Network : Green
Direct Access SP - YES

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

Remarks :

☐ Acute ☐ Pre-existing and chronic ☐ Maternity

Chief Complaints : severe sore throat and body pain and fever started on 12/11/2023 and respiratory difficulty started today

Duration:

Vitals:Temp : 36.5 Bp :90 Pulse :78 Resp :22

Clinical Findings:

Diagnosis: J02.9 - Acute pharyngitis, unspecified,J20.9 - Acute bronchitis, unspecified,R05 - Cough,R06.2 - Wheezing,R50.9 - Fever, unspecified, Date of Onset :14/17/2023

Requested Investigations: 0102-100104-1001, SODIUM CHLORIDE & DEXTROSE B.P.,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,0005-149902-1021, CLOFEN ,0005-111805-1021, CHLOROHISTOL 10MG-(CHLORPHENIRAMINE MALEATE : 10 MG/ML) SOLUTION FOR INJECTION,96374, THER/PROPH/DIAG INJ IV PUSH,96360, HYDRATION IV INFUSION INIT,94640, AIRWAY INHALATION TREATMENT,0188-135906-2441, PULMICORT,0006-124513-2071, VENTOLIN NEBULES,9, Consultation GP

Estimated :
Cost

Prescriptions: 0005-116801-1162 - (SODIUM CITRATE : 57 MG/5ML) (AMMONIUM CHLORIDE : 131.5 MG/5 ML) (MENTHOL : 1.1 MG/5 ML) (DIPHENHYDRAMINE : 13.5 MG/5ML) SYRUP,0252-389802-1171 - (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE HCL : 30 MG) TABLETS,0139-116207-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 500 MG) 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 :

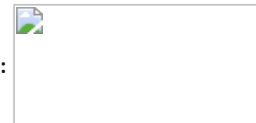
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Sajid Sanaullah

Stamp :



Patient's signature(Parent : if minor)



14-
Date : Nov-2023

Signature :

Date : 14-Nov-2023