Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: ZUHAYR ALI**	**Service Date**	**:16-Nov-2023**
Card No	**: I017-029-116381377-02**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	**: ZUHAYR ALI**	**Doctor's Name**	**:Sajid Sanaullah**
Payer Name	**: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	**:**
TPA	**: E CARE - Blue Network**	**Remarks**	**:**
Validity	**: 26-01-2023** To **25-01-2024**		
Gender	**: Male**		
Date Of Birth	**: 28-Feb-2018**		
Patient's Tel No	**: 0563097844**		

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 : C/o: Fever since 2days. Has associated pain in throat, but no chest pain. Has been vomiting, had 3 episodes today. Now complaint of extreme weakness and generalized body pains. **Duration:**

Vitals: Temp : 38 Bp :0 Pulse :110 Resp :24

Clinical Findings:

Diagnosis: J03.90 - Acute tonsillitis, unspecified,J02.9 - Acute pharyngitis, unspecified,R07.0 - Pain in throat,R05 - Cough,R50.9 - Fever, unspecified, **Date of Onset** :16/01/2023

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0015-107901-0392 - (IBUPROFEN : 200 MG) FILM COATED TABLETS,0139-116204-2151 - (CLAVULANIC ACID : 57 MG/5ML) (AMOXICILLIN : 400 MG/5ML) POWDER FOR SYRUP,0005-114501-2481 - (AMBROXOL : 15 MG/5ML) SYRUP (SUGAR FREE),1541-290302-0391 - (LEVOCETIRIZINE (DIHCL OR HCL) : 5MG) 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 : Sajid Sanaullah

Stamp :

Signature :

Date : 16-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 : 16-Nov-2023