Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **SHUBHAM BAWEJA BIHARI LAL BAWEJA**	**Service Date**	**:25-Nov-2023**	**Network**	: Green
Card No	: **I017-029-117640205-02**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	: **SHUBHAM BAWEJA BIHARI LAL BAWEJA**	**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	: **19-Jun-1997**				
Patient's Tel No	: **0563645343**				

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 : throat pain from 23/11/2023 and stomach pain and nose fullness **Duration :**

Vitals: Temp : 36.4 Bp :110 Pulse :76 Resp :22

Clinical Findings:

Diagnosis: J02.9 - Acute pharyngitis, unspecified,J01.00 - Acute maxillary sinusitis, unspecified, **Date of Onset** :25/17/2023

Requested Investigations: 0006-124513-2071, VENTOLIN NEBULES,94640, AIRWAY INHALATION TREATMENT,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,0195-107704-0802, CEFTRIAXONE-TABUK IM,0102-100104-1001, SODIUM CHLORIDE & DEXTROSE B.P.,96372, THER/PROPH/DIAG INJ SC/IM,96360, HYDRATION IV INFUSION INIT,0005-149902-1021, CLOFEN ,9, Consultation GP **Estimated Cost :**

Prescriptions: 0252-107001-1171 - (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) TABLETS,0248-135501-1161 - (DEXTROMETHORPHAN : 125 MG/100ML) (DIPHENHYDRAMINE : 100 MG/100ML) (EPHEDRINE : 150 MG/100 ML) (GUAIFENESIN : 10 MG/ML) SYRUP,0139-116206-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 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} : **Date :** 25-Nov-2023

Signature :

Date : 25-Nov-2023