

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : VALDINE TAMARA OLUOH
Card No : I017-029-119736228-01
Policy Holder : VALDINE TAMARA OLUOH
Payer Name : ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC
TPA : E CARE - Green Network
Validity : 01-10-2023 To 30-09-2024
Gender : Female
Date Of Birth : 03-Jan-1998
Patient's Tel No : 0521763528

Service Date : 27-Nov-2023
Health Provider : Irham Medical Center Arjan
Doctor's Name : Sajid Sanaullah
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 : Severe pain in body and loss of appetite and chills since three days started and severe stomach pain and reflux since 20/11/2023

Vitals:Temp : 36.2 Bp :122 Pulse :85 Resp :22

Clinical Findings:

Diagnosis: J02.9 - Acute pharyngitis, unspecified,R68.83 - Chills (without fever),K21.9 - Gastro-esophageal reflux disease without esophagitis,K29.00 - Acute gastritis without bleeding,N39.0 - Urinary tract infection, site not specified,J01.00 - Acute maxillary sinusitis, unspecified,

Date of Onset : 27/48/2023

Requested Investigations: 9, Consultation GP,0102-100104-1001, SODIUM CHLORIDE & DEXTROSE B.P.,0195-107704-0801, CEFTRIAXONE-TABUK IV,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,0005-149902-1021, CLOFEN ,96360, HYDRATION IV INFUSION INIT,0005-242802-0781, PANTONIX 40MG I.V.,96374, THER/PROPH/DIAG INJ IV PUSH,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,85651, SEDIMENTATION RATE RBC NON AUTOMATED,86140, C REACTIVE PROTEIN,81015, URINALYSIS MICROSCOPIC ONLY

Estimated : Cost

Prescriptions: 0669-242802-3261 - (PANTOPRAZOLE (AS SODIUM) : 40 MG) DELAYED RELEASE TABLET,4417-711202-0391 - (IBUPROFEN (AS L-ARGININE SALT) : 400 MG) FILM COATED 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 :

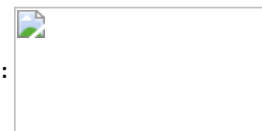
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Sajid Sanaullah

Stamp :



Patient's signature{Parent : if minor}



Date : Nov-2023

Signature :

Date : 27-Nov-2023