## Administrative MEDICAL CLAIM FORM Claim Ref:

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|---|---|---|---|---|---|
| **Patient Name** | : **NAWAJAHMED AKIL SAYYED AKIL JANMOHAMED SAYYED** | **Service Date** | **:04-Dec-2023** | **Network** | : Green |
| **Card No** | : **I017-029-116122371-02** | **Health Provider** | **:Irham Medical Center Arjan** | | **Direct Access SP - YES** |
| **Policy Holder** | : **NAWAJAHMED AKIL SAYYED AKIL JANMOHAMED SAYYED** | **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** | : **06-Jun-1998** | | | | |
| **Patient's Tel No** | : **0586644103** | | | | |

| 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 :** cough and sore throat from 2/12/2023 **Duration :**

**Vitals:**Temp : 37 Bp :118 Pulse :88 Resp :22

**Clinical Findings:**

**Diagnosis:** J02.9 - Acute pharyngitis, unspecified,R05 - Cough, **Date of Onset** : 04/50/2023

**Requested Investigations:** 0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,0195-107704-0802, CEFTRIAXONE-TABUK IM,9, Consultation GP,96372, THER/PROPH/DIAG INJ SC/IM **Estimated Cost** :

**Prescriptions:** 0202-185401-1161 - (CHLORPHENIRAMINE : 2 MG/5ML) (DEXTROMETHORPHAN : 30 MG/5ML) (PSEUDOEPHEDRINE : 10 MG/5ML) 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 :**

Dr. Sajid Sanaullah Khan
General Practitioner
DHA No: 05758224-001
PESHAWAR MEDICAL CENTER LLC
DUBAI - U.A.E.

**Patient 's signature{Parent : if minor}** **Date :** 04-Dec-2023

**Signature :** **Date** : 04-Dec-2023