

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : SOUKAINA EL HARAR

Card No : I017-029-116362606-02

Policy Holder : SOUKAINA EL HARAR

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 : 14-Oct-1998

Patient's Tel No : 0507437356

Service Date : 04-Dec-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 cough and wheezing since three days and started on 1/12/2023 and Duration: sore throat and body pain since 28/11/2023 received some medicines

Vitals: Temp : 36.4 Bp :108 Pulse :96 Resp :22

Clinical Findings:

Diagnosis: J02.9 - Acute pharyngitis, unspecified, J20.9 - Acute bronchitis, unspecified, R06.2 - Wheezing, R05 - Cough, **Date of Onset** : 04/29/2023

Requested Investigations: 0102-100104-1001, SODIUM CHLORIDE & DEXTROSE B.P., 0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE, 0005-111805-1021, CHLOROHISTOL 10MG, 0195-107704-0801, CEFTRIAXONE-TABUK IV, 96360, HYDRATION IV INFUSION INIT, 94640, AIRWAY INHALATION TREATMENT, 0188-135906-2441, PULMICORT, 0006-124513-2071, VENTOLIN NEBULES, 9, Consultation GP, 96374, THER/PROPH/DIAG INJ IV PUSH **Estimated : Cost**

Prescriptions: 0015-101502-0271 - (ACETYLCYSTEINE : 600 MG) EFFERVESCENT TABLETS, 0005-116801-1161 - (SODIUM CITRATE : 57 MG/5ML) (AMMONIUM CHLORIDE : 131.5 MG/5 ML) (MENTHOL : 1.1 MG/5 ML) (DIPHENHYDRAMINE : 13.5 MG/5ML) SYRUP, 0006-402804-2481 - (SALBUTAMOL (AS SULPHATE) : 2 MG/5ML) SYRUP (SUGAR FREE), 0097-127405-0392 - (AZITHROMYCIN : 500 MG) 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.

PATIENT'S DECLARATION :

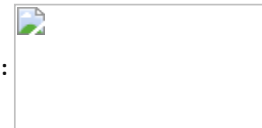
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Sajid Sanaullah

Stamp :



Patient's signature {Parent : if minor}



Date : Dec-2023

Signature :

Date : 04-Dec-2023