Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **RABIN KADEL THANNA BAHADUR KADEL**	**Service Date**	**:05-Dec-2023**
Card No	: **I017-029-117588521-02**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	: **RABIN KADEL THANNA BAHADUR KADEL**	**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	: **10-Oct-1998**		
Patient's Tel No	: **0569282742**		

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 : cough and sputum from one week ago after last visit **Duration :**

Vitals: Temp : 36.4 Bp :103 Pulse :83 Resp :22

Clinical Findings:

Diagnosis: J01.00 - Acute maxillary sinusitis, unspecified,J03.91 - Acute recurrent tonsillitis, unspecified,R09.3 - Abnormal sputum, **Date of Onset** :05/26/2023

Requested Investigations: 9, Consultation GP,0006-124513-2071, VENTOLIN NEBULES,94640, AIRWAY INHALATION TREATMENT **Estimated Cost** :

Prescriptions: 0009-134003-1161 - (BROMHEXINE HYDROCHLORIDE : 4 MG/5ML) SYRUP,6076-482003-0392 - (CIPROFLOXACIN (AS HYDROCHLORIDE) : 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 : 05-Dec-2023

Signature :

Date : 05-Dec-2023