

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : GRACE REHEMA CHAO

Card No : I017-029-117408180-02

Policy Holder : GRACE REHEMA CHAO

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 : 30-Dec-1984

Patient's Tel No : 526504377

Service Date : 08-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 sore throat and high fever started yesterday on 7/12/2023 severe cough and sneezing since today and wheezing

Vitals:Temp : 37.1 Bp :104 Pulse :85 Resp :22

Clinical Findings:

Diagnosis: J02.9 - Acute pharyngitis, unspecified,J20.9 - Acute bronchitis, unspecified,R09.81 - Nasal congestion, Date of Onset:08/19/2023

Requested Investigations: 9, Consultation GP,0102-100104-1001, SODIUM CHLORIDE & DEXTROSE B.P.,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,0005-149902-1021, CLOFEN ,0005-111805-1021, CHLOROHISTOL 10MG,96360, HYDRATION IV INFUSION INIT,96374, THER/PROPH/DIAG INJ IV PUSH,94640, AIRWAY INHALATION TREATMENT,0188-135906-2441, PULMICORT,0006-124513-2071, VENTOLIN NEBULES

Prescriptions: 0006-402804-2481 - (SALBUTAMOL(AS SULPHATE) : 2 MG/5ML) SYRUP (SUGAR FREE),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,0252-389802-1171 - (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE HCL : 30 MG) TABLETS,0097-116207-0391 - (AMOXICILLIN : 500 MG) (CLAVULANIC ACID : 125 MG) FILM COATED TABLETS,

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 :

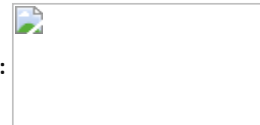
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Sajid Sanaullah

Stamp :



Patient's signature{Parent : if minor}



Date : Dec-2023

Signature :

Date : 08-Dec-2023