Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: CHERRY THEIN**	**Service Date**	**:10-Dec-2023**	**Network**	**:** Green
Card No	**: I017-029-119448899-01**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	**: CHERRY THEIN**	**Doctor's Name**	**:Sajid Sanaullah**		
Payer Name	**: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:		
TPA	**: E CARE - Green Network**	**Remarks**	**:**		
Validity	**: 01-10-2023** To **30-09-2024**				
Gender	**: Female**				
Date Of Birth	**: 29-Jun-1992**				
Patient's Tel No	**: 0529351779**				

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 : Severe cough and body pain and fever started since 7/12/2023 severe respiratory difficulty and stridor started today morning **Duration:**

Vitals: Temp : 36.7 Bp :100 Pulse :79 Resp :22

Clinical Findings:

Diagnosis: R06.1 - Stridor,M62.81 - Muscle weakness (generalized),J35.1 - Hypertrophy of tonsils,J04.0 - Acute laryngitis,J02.9 - Acute pharyngitis, unspecified, **Date of Onset** **:**10/40/2023

Requested Investigations: 9, Consultation GP,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,96374, THER/PROPH/DIAG INJ IV PUSH,94640, AIRWAY INHALATION TREATMENT,0188-135906-2441, PULMICORT,0006-124513-2071, VENTOLIN NEBULES **Estimated Cost** **:**

Prescriptions: 0252-389802-1171 - (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE HCL : 30 MG) TABLETS,0139-116206-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) 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, **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 :** 10-Dec-2023

Signature :  **Date** **:** 10-Dec-2023