

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : CHERRY THEIN
 Card No : I017-029-119448899-01
 Policy Holder : CHERRY THEIN

Service Date :10-Dec-2023
 Health Provider :Irham Medical Center Arjan
 Doctor's Name :Sajid Sanaullah

Network : Green
 Direct Access SP - YES

Payer Name : ABU DHABI NATIONAL
 : INSURANCE COMPANY-ADNIC

Co-Insurance	CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
	10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

TPA : E CARE - Green Network
 Validity : 01-10-2023 To 30-09-2024

Remarks :

Gender : Female
 Date Of Birth : 29-Jun-1992
 Patient's Tel No : 0529351779

☐ 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 :

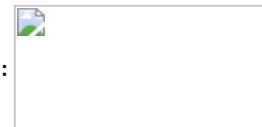
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Sajid Sanaullah

Stamp :



Patient's signature{Parent : if minor}



10-Date : Dec-2023

Signature :

Date : 10-Dec-2023