

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : JASIM UDDIN CHURUK
 Card No : I017-029-119448899-01
 Policy Holder : JASIM UDDIN CHURUK
 MIAH

Payer Name : ABU DHABI NATIONAL
 INSURANCE COMPANY-ADNIC

TPA : E CARE - Green Network

Validity : 01-01-1900 To 30-09-2024

Gender : Male

Date Of Birth : 22-Jun-1988

Patient's Tel No : 0507278477

Service Date :12-Dec-2023

Network : Green

Health Provider :Irham Medical Center Arjan

Direct Access SP - YES

Doctor's Name :Sajid Sanaullah

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 nasal secretion since three days started on 9/12/2023 and Duration: severe respiratory difficulty started today

Vitals:Temp : 36.2 Bp :115 Pulse :74 Resp :22

Clinical Findings:

Diagnosis: J02.9 - Acute pharyngitis, unspecified,J68.0 - Bronchitis & pneumonitis d/t chemicals, gas, fumes & vapors,R06.2 - Wheezing,R06.03 - Acute respiratory distress, Date of Onset :12/43/2023

Requested Investigations: 0195-107704-0802, CEFTRIAXONE-TABUK IM,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,0005-111805-1021, CHLOROHISTOL 10MG,96372, THER/PROPH/DIAG INJ SC/IM,94640, AIRWAY INHALATION TREATMENT,0188-135906-2441, PULMICORT,0006-124513-2071, VENTOLIN NEBULES,9, Consultation GP Estimated : Cost

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,0139-116206-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) 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 :

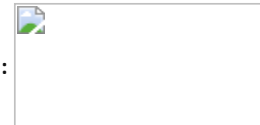
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Sajid Sanaullah

Stamp :



Patient's signature{Parent : if minor}



12-Date : Dec-2023

Signature :

Date : 12-Dec-2023