Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **JAMAL BISWAS ABDUL HALIM BISWAS**	**Service Date**	**:12-Dec-2023**	**Network**	**:** Green
Card No	: **I017-029-119293450-01**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	: **JAMAL BISWAS ABDUL HALIM BISWAS**	**Doctor's Name**	**:Enomen Goodluck**		
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	: **Male**				
Date Of Birth	: **09-Mar-1998**				
Patient's Tel No	: **971509956386**				

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 : C/o: Extreme weakness, cough, fever, headache, Aldo nasal congestion and nasal discharge. Also burning eyes. **Duration:**

Vitals: Temp : 37.1 Bp :115 Pulse :81 Resp :22

Clinical Findings:

Diagnosis: J00 - Acute nasopharyngitis [common cold],J02.9 - Acute pharyngitis, unspecified,J22 - Unspecified acute lower respiratory infection,R06.7 - Sneezing, **Date of Onset** :12/07/2023

Requested Investigations: 9, Consultation GP **Estimated Cost :**

Prescriptions: 0047-119805-1172 - (PREDNISOLONE : 5 MG) TABLETS,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,0139-116206-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS,0005-116801-2481 - (SODIUM CITRATE : 57 MG/5ML) (AMMONIUM CHLORIDE : 131.5 MG/5 ML) (MENTHOL : 1.1 MG/5 ML) (DIPHENHYDRAMINE : 13.5 MG/5ML) SYRUP (SUGAR FREE),0696-107902-0392 - (IBUPROFEN : 400 MG) FILM COATED TABLETS,0252-185801-0391 - (DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 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 : Enomen Goodluck **Stamp :**

Patient 's signature{Parent if minor} : **Date :** 12-Dec-2023

Signature : **Date** : 12-Dec-2023