Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **ANUGYA ARYA AMARESH PRASAD**	**Service Date**	**:17-Dec-2023**	**Network**	: Green
Card No	: **I017-029-117996524-02**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	: **ANUGYA ARYA AMARESH PRASAD**	**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	: **11-Nov-1996**				
Patient's Tel No	: **0527962012**				

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 : ACUTE SINUSITIS, WITHOUT FEVER **Duration :**

Vitals: Temp : 36.8 Bp :95 Pulse :82 Resp :22

Clinical Findings:

Diagnosis: R68.83 - Chills (without fever),J11.1 - Flu due to unidentified influenza virus w oth resp manifest,J01.80 - Other acute sinusitis,M79.10 - Myalgia, unspecified site, **Date of Onset** :17/01/2023

Requested Investigations: 0102-100104-1001, SODIUM CHLORIDE & DEXTROSE B.P.-(SODIUM CHLORIDE : 0.9%) (DEXTROSE : 5%) SOLUTION FOR INFUSION,96365, THER/PROPH/DIAG IV INF INIT,0005-111805-1021, CHLOROHISTOL 10MG-(CHLORPHENIRAMINE MALEATE : 10 MG/ML) SOLUTION FOR INJECTION,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,85652, SEDIMENTATION RATE RBC AUTOMATED,86140, C REACTIVE PROTEIN,82565, CREATININE BLOOD,84132, POTASSIUM SERUM PLASMA/WHOLE BLOOD,84295, SODIUM SERUM PLASMA OR WHOLE BLOOD,9.01, Follow Up Consultation GP **Estimated Cost :**

Prescriptions: **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 :** 17-Dec-2023

Signature :  **Date** : 17-Dec-2023