Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: ABIBSHA KHADKA**	**Service Date**	**:21-Dec-2023**	**Network**	**:** Green
Card No	**: I017-029-118969416-01**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	**: ABIBSHA KHADKA**	**Doctor's Name**	**:Sajid Sanaullah**		
Payer Name	**: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:		
TPA	**: E CARE - Green Network**	**Remarks**	**:**		
Validity	**: 01-01-1900** To **30-09-2024**				
Gender	**: Female**				
Date Of Birth	**: 30-Sep-1999**				
Patient's Tel No	**: 0581877261**				

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 : ear pain, all muscular pain, ACUTE SINUSITIS, FEVER WITH CHILLS **Duration :**

Vitals: Temp : 36.7 Bp :120 Pulse :1 Resp :22

Clinical Findings:

Diagnosis: R50.9 - Fever, unspecified,J01.20 - Acute ethmoidal sinusitis, unspecified,R09.81 - Nasal congestion,M79.10 - Myalgia, unspecified site, **Date of Onset** **:**21/51/2023

Requested Investigations: 0005-111805-1021, CHLOROHISTOL 10MG-(CHLORPHENIRAMINE MALEATE : 10 MG/ML) SOLUTION FOR INJECTION,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,0102-100104-1001, SODIUM CHLORIDE & DEXTROSE B.P.-(SODIUM CHLORIDE : 0.9%) (DEXTROSE : 5%) SOLUTION FOR INFUSION,0195-107704-0802, CEFTRIAXONE-TABUK IM,96372, THER/PROPH/DIAG INJ SC/IM,96365, THER/PROPH/DIAG IV INF INIT,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,85652, SEDIMENTATION RATE RBC AUTOMATED,86140, C REACTIVE PROTEIN,84520, UREA NITROGEN QUANTITATIVE,82565, CREATININE BLOOD,84295, SODIUM SERUM PLASMA OR WHOLE BLOOD,84132, POTASSIUM SERUM PLASMA/WHOLE BLOOD,9, Consultation GP,96360, HYDRATION IV INFUSION INIT **Estimated : Cost**

Prescriptions: 1389-416601-1171 - (PANTOTHENIC ACID (VITAMIN B5) : 20 MG) (ZINC : 15 MG) (CYSTEINE : 40 MG) (CARNITINE : 30 MG) (BETACAROTENE : 3 MG) (IRON : 8 MG) (RIBOFLAVINE (VITAMIN B2) : 6 MG) (CHROMIUM : 100 MCG) (VITAMIN B12 : 14 MCG) (FOLIC ACID : 500 MCG) (THIAMINE (VITAMIN B1) : 18 MG) (NIACIN (VITAMIN B3; NICOTINIC ACID) : 27 MG) (PYRIDOXINE (VITAMIN B6) : 10 MG) (ASCORBIC ACID (VITAMIN C) : 150 MG) (VITAMIN A : 800 MCG) (VITAMIN E : 40 MG) (SELENIUM : 180 MCG) (COPPER : 0.5 MG) (MANGANESE : 4 MG) (VITAMIN K : 70 MCG),0015-101502-0271 - (ACETYLCYSTEINE : 600 MG) EFFERVESCENT TABLETS,0788-106705-1171 - (CHLORPHENIRAMINE MALEATE : 2 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) TABLETS,0027-265802-1161 - (BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V) SYRUP,1307-127402-1451 - (AZITHROMYCIN : 250 MG) CAPSULES (HARD GELATIN),

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.

Dr's Name : Sajid Sanaullah

Stamp :

Signature :

Date : 21-Dec-2023

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.

Patient 's signature{Parent if minor} :

Date : 21-Dec-2023