Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **MOHSIN KHAN MOHAMMED NIYAZ**	**Service Date**	**:25-Dec-2023**
Card No	: **I017-029-117360009-02**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	: **MOHSIN KHAN MOHAMMED NIYAZ**	**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	: **Male**		
Date Of Birth	: **01-Sep-1982**		
Patient's Tel No	: **0589929842**		

Network : Green

Direct Access SP - YES

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 : HEADACHE IN FRONT OF THE HEAD AFTER VIRAL INFECTION, pain in nasopharynx, dry and wet cough, all muscular pain **Duration:**

Vitals: Temp : 36.8 Bp :110 Pulse :82 Resp :22

Clinical Findings:

Diagnosis: R05 - Cough,R50.9 - Fever, unspecified,R07.0 - Pain in throat,M79.10 - Myalgia, unspecified site,R53.1 - Weakness, **Date of Onset** :25/50/2023

Requested Investigations: 0102-100104-1001, SODIUM CHLORIDE & DEXTROSE B.P.-(SODIUM CHLORIDE : 0.9%) (DEXTROSE : 5%) SOLUTION FOR INFUSION,96360, HYDRATION IV INFUSION INIT,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,96365, THER/PROPH/DIAG IV INF INIT,0005-111805-1021, CHLOROHISTOL 10MG-(CHLORPHENIRAMINE MALEATE : 10 MG/ML) SOLUTION FOR INJECTION,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,0195-107704-0802, CEFTRIAXONE-TABUK IM,96372, THER/PROPH/DIAG INJ SC/IM,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,0006-124513-2071, VENTOLIN NEBULES,9, Consultation GP,96374, THER/PROPH/DIAG INJ IV PUSH,94640, AIRWAY INHALATION TREATMENT,96365, THER/PROPH/DIAG IV INF INIT **Estimated Cost** :

Prescriptions: 0788-106705-1171 - (CHLORPHENIRAMINE MALEATE : 2 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) TABLETS,1144-253101-1162 - (HEDERA HELIX (IVY) : 7MG/ML) SYRUP,4075-183201-0391 - (FEXOFENADINE HCL : 120 MG) FILM COATED TABLETS,1307-127402-1451 - (AZITHROMYCIN : 250 MG) CAPSULES (HARD GELATIN), **Estimated Cost** :

MEDICAL PRACTITIONER DECLARATION :

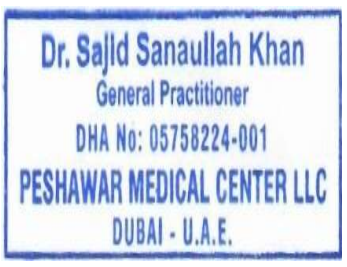
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

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} :

Date : 25-Dec-2023

Signature :  **Date :** 25-Dec-2023