# Administrative MEDICAL CLAIM FORM Claim Ref:

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|---|---|---|---|
| **Patient Name** | : **VEERA JYOTHI KUMAR THIMMANANA ANANDA RAO THIMMANANA** | **Service Date** | **:11-Jan-2024** |
| **Card No** | : **I017-029-117673071-02** | **Health Provider** | **:Irham Medical Center Arjan** |
| **Policy Holder** | : **VEERA JYOTHI KUMAR THIMMANANA ANANDA RAO THIMMANANA** | **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** | : **07-Aug-2000** | | |
| **Patient's Tel No** | : **0545902559** | | |

**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 :** SEVERE NASAL HIT AT HOME BY SOME OBJECT SUSPECTED TO NOSE FRACTURE HAPPENED TODAY MORNING 11/1/2024 **Duration:**

**Vitals:**Temp : 36.7 Bp :126 Pulse :82 Resp :22

**Clinical Findings:**

**Diagnosis:** S02.2XXA - Fracture of nasal bones, init encntr for closed fracture,G89.11 - Acute pain due to trauma, **Date of Onset:**11/21/2024

**Requested Investigations:** 0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,0005-149902-1021, CLOFEN ,96372, THER/PROPH/DIAG INJ SC/IM,51.01, Non-surgical cleansing with surgical dressing 16 sq inches / 100 sq centimeters or less **Estimated Cost** :

**Prescriptions:** 4179-711202-0391 - (IBUPROFEN (AS L-ARGININE SALT) : 400 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** : Sajid Sanaullah **Stamp :**


**Patient 's signature{Parent : if minor}**

**Date :** 11-Jan-2024

**Signature :**

**Date** : 11-Jan-2024