Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **ARIFUL ISLAM MOHAMED MOFIZUL ISLAM**	**Service Date**	**:21-Jan-2024**	**Network**	: Green
Card No	: **I017-029-117170354-02**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	: **ARIFUL ISLAM MOHAMED MOFIZUL ISLAM**	**Doctor's Name**	**:Sajid Sanaullah**		
Payer Name	: **ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:		
TPA	: **E CARE - Blue Network**	**Remarks**	:		
Validity	: **01-10-2023** To **30-09-2024**				
Gender	: **Male**				
Date Of Birth	: **05-Jul-1986**				
Patient's Tel No	: **0554435294**				

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 coughing 3 days,itching in throat since 3 days ,itching on digits of hands and feet associated with eruption of skin on examinatio chest congested throat hypremic fungal leison on digits of hand and feet **Duration:**

Vitals: Temp : 36.8 Bp :121 Pulse :87 Resp :22

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,B35.9 - Dermatophytosis, unspecified,B35.3 - Tinea pedis,R52 - Pain, unspecified,R05 - Cough, **Date of Onset** :21/46/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0005-101701-0391 - (ACECLOFENAC : 100 MG) FILM COATED TABLETS,0005-119805-1173 - (PREDNISOLONE : 5 MG) TABLETS,0207-140504-0151 - (CLOTRIMAZOLE : 1%) CREAM,0067-116705-1161 - (DIPHENHYDRAMINE : 14 MG/5 ML) SYRUP,2733-646901-3851 - (IPRATROPIUM BROMIDE MONOHYDRATE : 0.6 MG/ML) (XYLOMETAZOLINE HCL : 0.5 MG/ML) NASAL SPRAY,0009-127405-0391 - (AZITHROMYCIN : 500 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 : 21-Jan-2024

Signature :

Date : 21-Jan-2024