Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **ABDUL RAUF REHMAT ULLAH**	**Service Date**	**:28-Jan-2024**	**Network**	: Green
Card No	: **I017-029-115381312-02**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	: **ABDUL RAUF REHMAT ULLAH**	**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-Jan-1962**				
Patient's Tel No	: **0554356612**				

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 cough and nasal block and headache since yesterday night 27/1/2024 **Duration:** severe cough since today

Vitals: Temp : 36.2 Bp :146 Pulse :62 Resp :22

Clinical Findings:

Diagnosis: J01.40 - Acute pansinusitis, unspecified,J02.9 - Acute pharyngitis, unspecified,J30.9 - Allergic rhinitis, unspecified,R05 - Cough,R09.81 - Nasal congestion, **Date of Onset** :28/44/2024

Requested Investigations: 9, Consultation GP,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,0005-111805-1021, CHLOROHISTOL 10MG,96372, THER/PROPH/DIAG INJ SC/IM,94640, AIRWAY INHALATION TREATMENT,0188-135906-2441, PULMICORT,0006-124513-2071, VENTOLIN NEBULES **Estimated Cost** :

Prescriptions: 0027-128802-1971 - (XYLOMETAZOLINE HYDROCHLORIDE : 0.1%) LIQUID FOR SPRAY (NASAL),0252-389802-1171 - (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE HCL : 30 MG) TABLETS,0139-116206-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) 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 : 28-Jan-2024

Signature :

Date : 28-Jan-2024