Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **NIMESH PALLEK KANKANAMGE DON**	**Service Date**	**:02-Feb-2024**	**Network**	: Green
Card No	: **I017-029-117651570-02**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	: **NIMESH PALLEK KANKANAMGE DON**	**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	: **21-Aug-1994**				
Patient's Tel No	: **971589576261**				

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 EAR PAIN SINCE THREE DAYS STARTED 30/1/2024 USED WAX REMOVAL DROPS BUT NO BENEFIT AS HAS OTITIS MEDIA **Duration:**

Vitals: Temp : 36.7 Bp :115 Pulse :82 Resp :22

Clinical Findings:

Diagnosis: H66.005 - Ac suppr otitis media w/o spon rupt ear drum, recur, l ear,H65.112 - Acute and subacute allergic otitis media (serous), left ear,R09.81 - Nasal congestion, **Date of Onset** :02/40/2024

Requested Investigations: 9, Consultation GP,0195-107704-0802, CEFTRIAXONE-TABUK IM,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,0005-149902-1021, CLOFEN ,0005-111805-1021, CHLOROHISTOL 10MG,96372, THER/PROPH/DIAG INJ SC/IM **Estimated Cost** :

Prescriptions: 0252-148701-1171 - (LORATADINE : 10 MG) TABLETS,0027-128802-1971 - (XYLOMETAZOLINE HYDROCHLORIDE : 0.1%) LIQUID FOR SPRAY (NASAL),4417-711202-0391 - (IBUPROFEN (AS L-ARGININE SALT) : 400 MG) FILM COATED 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 : 02-Feb-2024

Signature :

Date : 02-Feb-2024