Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: EI THET HTAR KHIN**	**Service Date**	**:04-Feb-2024**
Card No	**: I017-029-120176773-01**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	**: EI THET HTAR KHIN**	**Doctor's Name**	**:Sajid Sanaullah**
Payer Name	**: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:
TPA	**: E CARE - Green Network**	**Remarks**	:
Validity	**: 01-01-1900** To **30-09-2024**		
Gender	**: Female**		
Date Of Birth	**: 20-Jun-1999**		
Patient's Tel No	**: 505437451**		

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 : C/O PAIN IN THROAT ,FEVER,COUGH ,BODY PAIN AND HOARSNESS OF VOICE **Duration:** SINCE 3 DAYS

Vitals: Temp : 36.8 Bp :109 Pulse :82 Resp :20

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,J03.90 - Acute tonsillitis, unspecified,R05 - Cough,R09.89 - Oth symptoms and signs involving the circ and resp systems,R50.9 - Fever, unspecified, **Date of Onset** :04/19/2024

Requested Investigations: 2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,96365, THER/PROPH/DIAG IV INF INIT,0005-111805-1021, CHLOROHISTOL 10MG-(CHLORPHENIRAMINE MALEATE : 10 MG/ML) SOLUTION FOR INJECTION,96374, THER/PROPH/DIAG INJ IV PUSH,0195-107704-0802, CEFTRIAXONE-TABUK IM-(CEFTRIAXONE : 1 G) POWDER FOR INJECTION,0188-135906-2441, PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION,94640, AIRWAY INHALATION TREATMENT,9, Consultation GP **Estimated Cost :**

Prescriptions: 1144-253101-1162 - (HEDERA HELIX (IVY) : 7MG/ML) SYRUP,0006-106601-0392 - (PARACETAMOL : 500 MG) FILM COATED TABLETS,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,0005-119805-1173 - (PREDNISOLONE : 5 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 : 04-Feb-2024

Signature :

Date : 04-Feb-2024