

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name

MARY IRENE WANJIKU MUNGAI

Card No

: I017-029-116868471-02

Policy Holder

MARY IRENE WANJIKU MUNGAI

Payer Name

ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC

TPA

: E CARE - Green Network

Validity

: 01-10-2023 To 30-09-2024

Gender

: Female

Date Of Birth

: 01-Jan-1992

Patient's Tel No

: 0563728901

Service Date

:05-Feb-2024

Health Provider

:Irham Medical Center Arjan

Doctor's Name

:Sajid Sanaullah

Co-Insurance

Network

: Green

Direct Access SP - YES

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

Remarks

:

☐ Acute

☐ Pre-existing and chronic

☐ Maternity

Chief Complaints

: c/o headache ,dry cough ,sore throat ,sneezing and nasal congestion

Duration :

Vitals

:Temp : 36.8 Bp :115 Pulse :82 Resp :18

Clinical Findings:

Diagnosis:

J02.9 - Acute pharyngitis, unspecified,R05 - Cough,R07.0 - Pain in throat,R06.7 - Sneezing,R09.81 - Nasal congestion,R51.9 - Headache, unspecified,

Date of Onset

:05/18/2024

Requested Investigations:

0188-135906-2441, PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION,94640, AIRWAY INHALATION TREATMENT,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,0005-149902-1021, CLOFEN - (DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,9, Consultation GP

Estimated : Cost

Prescriptions:

3857-395404-0391 - (MONTELUKAST (AS SODIUM) : 10 MG) FILM COATED TABLETS,0006-106601-0392 - (PARACETAMOL : 500 MG) FILM COATED TABLETS,1144-253101-1162 - (HEDERA HELIX (IVY) : 7MG/ML) SYRUP,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,0397-116407-0391 - (AMOXICILLIN : 1000 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 :

Dr. Sajid Sanaullah Khan

General Practitioner

DHA No: 05758224-001

PESHAWAR MEDICAL CENTER LLC

DUBAI - U.A.E.

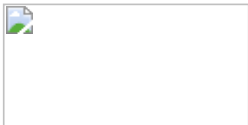
Signature :



Date

: 05-Feb-2024

Patient 's signature{Parent : if minor}



Date : Feb-2024

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