Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **MARY IRENE WANJIKU MUNGAI**	**Service Date**	**:05-Feb-2024**
Card No	: **I017-029-116868471-02**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	: **MARY IRENE WANJIKU MUNGAI**	**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	: **Female**		
Date Of Birth	: **01-Jan-1992**		
Patient's Tel No	: **0563728901**		

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 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 :

Patient 's signature{Parent : if minor}

Date : 05-Feb-2024

Signature :

Date : 05-Feb-2024