

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : MAHESH RIJAL BINOD KUMAR RIJAL

Card No : I017-029-117246737-02

Policy Holder : MAHESH RIJAL BINOD KUMAR RIJAL

Payer Name : ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC

TPA : E CARE - Green Network

Validity : 01-01-1900 To 30-09-2024

Gender : Male

Date Of Birth : 07-Oct-1999

Patient's Tel No : 0564673569

Service Date :05-Feb-2024

Health Provider :Irham Medical Center Arjan

Doctor's Name :Sajid Sanaullah

Co-Insurance :

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

Network : Green

Direct Access SP - YES

Remarks :

☐ Acute

☐ Pre-existing and chronic

☐ Maternity

Chief Complaints : C/o: Pain in throat, nasal congestion and nasal discharge with greenish color phlegm. There is associated generalized body pains, with weakness.

Vitals:Temp : 36.6 Bp :108 Pulse :80 Resp :18

Clinical Findings:

Diagnosis: J01.00 - Acute maxillary sinusitis, unspecified,J02.8 - Acute pharyngitis due to other specified organisms,R50.9 - Fever, unspecified,J30.9 - Allergic rhinitis, unspecified,

Date of Onset :05/40/2024

Requested Investigations: 9, Consultation GP

Estimated Cost :

Prescriptions: 1204-571401-1161 - (GUAIFENESIN : 100 MG/5ML) (PSEUDOEPHEDRINE HCL : 30 MG/5ML) (TRIPROLIDINE HCL : 1.25 MG/5ML) SYRUP,0139-116206-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,2027-560101-0391 - (IBUPROFEN : 150 MG) (PARACETAMOL : 500 MG) FILM COATED TABLETS,0252-185801-0391 - (DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 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.

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 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.

Patient 's signature{Parent : if minor}



Date : Feb-2024