

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : NATHANIEL WELCOME

Card No : I017-029-118348457-02

Policy Holder : NATHANIEL WELCOME

Payer Name : ABU DHABI NATIONAL
INSURANCE COMPANY-
ADNIC

TPA : E CARE - Green Network

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

Gender : Male

Date Of Birth : 12-Dec-1989

Patient's Tel No : 0569642461

Service Date : 06-Feb-2024

Health Provider : Irham Medical Center Arjan

Doctor's Name : Sajid Sanaullah

Network : Green

Direct Access SP - YES

Co-Insurance :

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

Remarks :

☐ Acute ☐ Pre-existing and chronic ☐ MaternityChief Complaints : C/O FEVER, HEADACHE, SORE THROAT, BODY PAIN SINCE 3 DAYS COUGHING 5 Duration:
DAYS ON EXAMINATION PATIENT HAS HYPREMIC THROAT AND CHEST CONGESTION

Vitals: Temp : 36.6 Bp : 137 Pulse : 72 Resp : 22

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified, J01.90 - Acute sinusitis, unspecified, R50.9 - Fever, Date of : 06/53/2024
unspecified, R05 - Cough, R52 - Pain, unspecified, J00 - Acute nasopharyngitis [common cold], OnsetRequested Investigations: 2040-106618-1001, PARACETAMOL S.A.L.F (PARACETAMOL : 10 MG/ML) Estimated :
SOLUTION FOR INFUSION, 0005-111805-1021, CHLORHISTOL 10MG-(CHLORPHENIRAMINE MALEATE Cost
: 10 MG/ML) SOLUTION FOR INJECTION, 96374, THER/PROPH/DIAG INJ IV PUSH, 0195-107704-0801,
CEFTRIAXONE-TABUK IV-(CEFTRIAXONE : 1 G) POWDER FOR INJECTION, 96365, THER/PROPH/DIAG IV
INF INIT, 9.01, Follow Up Consultation GPPrescriptions: 0006-106601-0392 - (PARACETAMOL : 500 MG) FILM COATED TABLETS, 0005-119805- Estimated :
1173 - (PREDNISOLONE : 5 MG) TABLETS, 0252-185801-0391 - (DIPHENHYDRAMINE : 25 MG) Cost
(PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS, 0139-116206-1171 -
(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS,

MEDICAL PRACTITIONER DECLARATION :

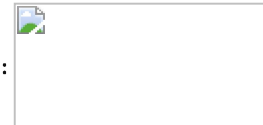
I declare that I am the patient's medical practitioner and that the particulars given are to
the best of my knowledge true and correct.

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}06-
Date : Feb-
2024

Signature :

Date : 06-Feb-2024