

Administrative

Patient Name : JERICK JAAN

Card No : I017-029-120241499-01

Policy Holder : JERICK JAAN

Payer Name : ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC

TPA : E CARE - Green Network

Validity : 22-12-2023 To 30-09-2024

Gender : Male

Date Of Birth : 18-Jul-1996

Patient's Tel No : 0586615594

MEDICAL CLAIM FORM

Service Date :09-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

Remarks :

Claim Ref:

Network : Green

Direct Access SP - YES

☐ Acute

☐ Pre-existing and chronic

☐ Maternity

Chief Complaints : c/o cough,snezing,headache,body pain and fever since 2 days

Duration :

Vitals:Temp : 36.7 Bp :120 Pulse :85 Resp :22

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,J00 - Acute nasopharyngitis [common cold],R05 - Cough,R50.9 - Fever, unspecified,E55.9 - Vitamin D deficiency, unspecified,R06.2 - Wheezing,R53.1 - Weakness,

Date of Onset :09/05/2024

Requested Investigations: 9, Consultation GP,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,85652, SEDIMENTATION RATE RBC AUTOMATED,82947, GLUCOSE QUANTITATIVE BLOOD XCPT REAGENT STRIP,82652, 1 25 DIHYDROXY INCLUDES FRACTIONS IF PERFORMED,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,0005-111805-1021, CHLOROHISTOL 10MG-(CHLORPHENIRAMINE MALEATE : 10 MG/ML) SOLUTION FOR INJECTION,0195-107704-0801, CEFTRIAXONE-TABUK IV,96365, THER/PROPH/DIAG IV INF INIT,96374, THER/PROPH/DIAG INJ IV PUSH,0188-135906-2441, PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION,94640, AIRWAY INHALATION TREATMENT

Estimated : Cost

Prescriptions: 0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED 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.

Dr's Name : Sajid Sanaullah

Signature : 

Stamp : 

Date : 09-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

https://irhamc.visionsoftwares.ae/mr_ecare_claim_print.aspx?appld=46062&patId=52482

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