Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **TONMOY GHOSH KALIPADA GHOSH**	**Service Date**	**:13-Feb-2024**	**Network**	: Green
Card No	: **I017-029-116125747-02**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	: **TONMOY GHOSH KALIPADA GHOSH**	**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	: **Male**				
Date Of Birth	: **10-Jun-1992**				
Patient's Tel No	: **0566769711**				

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 DRY COUGH,FLU ,FEVER AND BODY PAIN SINCE 3 DAYS O/E PT HAS HYPREMIC THROAT AND CHEST CONGESTION PT HAS PRURITIC LEISION ON HIS SCROTUM RECURRENT **Duration:**

Vitals: Temp : 36.7 Bp :128 Pulse :75 Resp :22

Clinical Findings:

Diagnosis: J02.9 - Acute pharyngitis, unspecified,R05 - Cough,R50.9 - Fever, unspecified,R52 - Pain, unspecified,N49.2 - Inflammatory disorders of scrotum,B36.9 - Superficial mycosis, unspecified, **Date of Onset** :13/23/2024

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,85651, SEDIMENTATION RATE RBC NON AUTOMATED,82947, GLUCOSE QUANTITATIVE BLOOD XCPT REAGENT STRIP,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,0195-107704-0802, CEFTRIAXONE-TABUK IM-(CEFTRIAXONE : 1 G) POWDER FOR INJECTION,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,0005-111805-1021, CHLOROHISTOL 10MG-(CHLORPHENIRAMINE MALEATE : 10 MG/ML) SOLUTION FOR INJECTION,96365, THER/PROPH/DIAG IV INF INIT,96374, THER/PROPH/DIAG INJ IV PUSH,9, Consultation GP **Estimated Cost :**

Prescriptions: 0207-214402-0151 - (BETAMETHASONE : N/A) (CLOTRIMAZOLE : N/A) CREAM,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,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.

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 : 13-Feb-2024

Signature :

Date : 13-Feb-2024