Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **PAPPU RAJAK RAM CHANDRA RAJAK**	**Service Date**	**:19-Feb-2024**
Card No	: **I017-029-116125943-02**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	: **PAPPU RAJAK RAM CHANDRA RAJAK**	**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	: **01-Jan-1987**		
Patient's Tel No	: **555208405**		

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: Raised red swelling widely distributed all over the body and associated with marked pruritus. **Duration:**

Vitals: Temp : 36.5 Bp :124 Pulse :85 Resp :22

Clinical Findings:

Diagnosis: L50.0 - Allergic urticaria, **Date of Onset** : 19/01/2024

Requested Investigations: 96374, THER/PROPH/DIAG INJ IV PUSH,0005-111805-1021, CHLOROHISTOL 10MG,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,9, Consultation GP **Estimated Cost** :

Prescriptions: 0005-119805-1172 - (PREDNISOLONE : 5 MG) TABLETS,1111-183202-0391 - (FEXOFENADINE HCL : 180 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 : 19-Feb-2024

Signature :

Date : 19-Feb-2024