Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **MARYANN NINA CABUENOS USON**	**Service Date**	**:19-Feb-2024**	**Network**	: Green
Card No	: **I017-029-117483918-02**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	: **MARYANN NINA CABUENOS USON**	**Doctor's Name**	**:Sajid Sanaullah**		
Payer Name	: **ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:		
TPA	: **E CARE - Green Network**				
Validity	: **01-01-1900** To **30-09-2024**	**Remarks**	:		
Gender	: **Female**				
Date Of Birth	: **20-Dec-1990**				
Patient's Tel No	: **971509630740**				

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: Cough since 5days (13/02/2023). Also chest pain and upper abdominal pain. Cough is productive of green phglem. **Duration:**

Vitals: Temp : 36.8 Bp :115 Pulse :74 Resp :22

Clinical Findings:

Diagnosis: J22 - Unspecified acute lower respiratory infection,J03.90 - Acute tonsillitis, unspecified,R07.9 - Chest pain, unspecified,K29.00 - Acute gastritis without bleeding, **Date of Onset** :19/37/2024

Requested Investigations: 9, Consultation GP,94640, AIRWAY INHALATION TREATMENT,0006-402803-2071, VENTOLIN NEBULES,0188-135906-2441, PULMICORT,96365, THER/PROPH/DIAG IV INF INIT,0195-107704-0801, CEFTRIAXONE-TABUK IV,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,0005-242802-0781, PANTONIX 40MG I.V. **Estimated Cost** :

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

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