Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: JACKILYN FLORES DE PEDRO**	**Service Date**	**:20-Feb-2024**	**Network**	**: Green**
Card No	**: I017-029-119384579-01**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	**: JACKILYN FLORES DE PEDRO**	**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	**: Female**				
Date Of Birth	**: 19-May-1992**				
Patient's Tel No	**: 0544975596**				

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,RUNNY NOSE ,BODYACHE AND NASAL CONGESTION SINCE 2 DAYS NO KNOWN MEDICINE ALLERGIES **Duration:**

Vitals: Temp : 36.6 Bp :102 Pulse :84 Resp :22

Clinical Findings:

Diagnosis: J00 - Acute nasopharyngitis [common cold],R50.9 - Fever, unspecified,R52 - Pain, unspecified,J02.9 - Acute pharyngitis, unspecified,R09.81 - Nasal congestion, **Date of Onset** :20/08/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0006-106601-0392 - (PARACETAMOL : 500 MG) FILM COATED TABLETS,0009-127405-0391 - (AZITHROMYCIN : 500 MG) FILM COATED TABLETS,0005-119805-1172 - (PREDNISOLONE : 5 MG) TABLETS,5251-624304-3591 - (AZELASTINE HCL : 1 MG/G) (FLUTICASONE PROPIONATE : 0.365 MG/G) SUSPENSION FOR NASAL SPRAY,0005-116801-1161 - (SODIUM CITRATE : 57 MG/5ML) (AMMONIUM CHLORIDE : 131.5 MG/5 ML) (MENTHOL : 1.1 MG/5 ML) (DIPHENHYDRAMINE : 13.5 MG/5ML) SYRUP,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 : 20-Feb-2024

Signature :

Date : 20-Feb-2024