Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: JOHN BARRY OMONDI**	**Service Date**	**:20-Feb-2024**
Card No	**: I017-029-119050814-01**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	**: JOHN BARRY OMONDI**	**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	**: 04-Nov-1999**		
Patient's Tel No	**: 0555219621**		

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: Flu symptoms, nasal congestion, pain in throat and sneezing. Developed epistaxis today with blood when he blows his nostrils. Had fever 2 days ago which has now resolved spontaneously. **Duration:**

Vitals: Temp : 36.5 Bp :120 Pulse :82 Resp :93

Clinical Findings:

Diagnosis: J00 - Acute nasopharyngitis [common cold],J30.9 - Allergic rhinitis, unspecified,R04.0 - Epistaxis, **Date of Onset :**20/11/2024

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,96374, THER/PROPH/DIAG INJ IV PUSH,0005-111805-1021, CHLOROHISTOL 10MG,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,96365, THER/PROPH/DIAG IV INF INIT,9, Consultation GP **Estimated Cost :**

Prescriptions: 0252-185801-0391 - (DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS,0097-116403-1451 - (AMOXICILLIN : 500 MG) CAPSULES (HARD GELATIN),0005-106601-0052 - (PARACETAMOL : 500 MG) CAPLETS,0027-128802-2021 - (XYLOMETAZOLINE HYDROCHLORIDE : 0.1%) NASAL DROPS,0195-123701-0391 - (CETIRIZINE HCL : 10 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