Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **DAVEED FRANCIS THEKKEVILATHARAYIL VALIYAMALIL JOHN DAVEED**	**Service Date**	**:22-Feb-2024**
Card No	: **I017-029-116524270-02**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	: **DAVEED FRANCIS THEKKEVILATHARAYIL VALIYAMALIL JOHN DAVEED**	**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-Jun-1961**		
Patient's Tel No	: **0507647201**		

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 : Cough and pain in throat since last 3 days. also fever and weakness. Known hypertensive and diabetic, but not on any medication. **Duration:**

Vitals: Temp : 36.6 Bp :14 Pulse :82 Resp :22

Clinical Findings:

Diagnosis: J01.41 - Acute recurrent pansinusitis,J02.9 - Acute pharyngitis, unspecified,I10 - Essential (primary) hypertension,E11.65 - Type 2 diabetes mellitus with hyperglycemia, **Date of Onset** :22/25/2024

Requested Investigations: 9, Consultation GP,80061, LIPID PANEL,82947, GLUCOSE QUANTITATIVE BLOOD XCPT REAGENT STRIP,83036, HEMOGLOBIN GLYCOSYLATED A1C **Estimated Cost** :

Prescriptions: 1516-107902-1171 - (IBUPROFEN : 400 MG) TABLETS,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,4874-125821-3801 - (POVIDONE IODINE : 0.45%) SPRAY SOLUTION,0139-116207-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 500 MG) TABLETS,1204-571401-1161 - (GUAIFENESIN : 100 MG/5ML) (PSEUDOEPHEDRINE HCL : 30 MG/5ML) (TRIPROLIDINE HCL : 1.25 MG/5ML) SYRUP, **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.

Dr's Name : Sajid Sanaullah

Stamp :

Signature :

Date : 22-Feb-2024

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.

Patient 's signature{Parent : if minor}

Date : 22-Feb-2024