Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **SONAL MILITHA KALUTHARA LEKAMLAGE**	**Service Date**	**:24-Feb-2024**	**Network**	**:** Green
Card No	: **I017-029-119014962-01**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	: **SONAL MILITHA KALUTHARA LEKAMLAGE**	**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	: **21-Feb-1996**				
Patient's Tel No	: **0527763267**				

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, pain in throat, fever and weakness. Has been surpressing the fever with panadol. **Duration:**

Vitals: Temp : 36.6 Bp :121 Pulse :69 Resp :22

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,J02.9 - Acute pharyngitis, unspecified,J30.9 - Allergic rhinitis, unspecified, **Date of Onset** :24/38/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0097-127405-0391 - (AZITHROMYCIN : 500 MG) FILM COATED TABLETS,4874-125821-3801 - (POVIDONE IODINE : 0.45%) SPRAY SOLUTION,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,0005-116801-2481 - (SODIUM CITRATE : 57 MG/5ML) (AMMONIUM CHLORIDE : 131.5 MG/5 ML) (MENTHOL : 1.1 MG/5 ML) (DIPHENHYDRAMINE : 13.5 MG/5ML) SYRUP (SUGAR FREE),1516-107902-1171 - (IBUPROFEN : 400 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 : 24-Feb-2024

Signature :

Date : 24-Feb-2024