

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : DENVER WILLIAM WILLIAM FLEMING
Card No : I017-029-116125763-02
Policy Holder : DENVER WILLIAM WILLIAM FLEMING
Payer Name : ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC
TPA : E CARE - Green Network
Validity : 01-10-2023 To 30-09-2024
Gender : Male
Date Of Birth : 03-Apr-1995
Patient's Tel No : 0526257206

Service Date : 27-Feb-2024
Health Provider : Irham Medical Center Arjan
Doctor's Name : Sajid Sanaullah

Network : Green
Direct Access SP - YES

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

Remarks :

☐ Acute
 ☐ Pre-existing and chronic
 ☐ Maternity

Chief Complaints : c/o backache ,headache,fever and flu since 2 days on examination pt has multiple measles like rashes in face and head no known medicine allergies

Vitals:Temp : 37.8 Bp :140 Pulse :75 Resp :22

Clinical Findings:

Diagnosis: B05.9 - Measles without complication,R50.9 - Fever, unspecified,R05 - Cough,M54.5 - Low back pain,R21 - Rash and other nonspecific skin eruption,

Date of Onset : 27/47/2024

Requested Investigations: 0005-149902-1021, CLOFEN ,0102-152902-1001, LACTATED RINGERS INJECTION USP-(CALCIUM CHLORIDE : N/A) (POTASSIUM CHLORIDE : N/A) (SODIUM CHLORIDE : N/A) (SODIUM LACTATE : N/A) SOLUTION FOR INFUSION,96360, HYDRATION IV INFUSION INIT,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,96374, THER/PROPH/DIAG INJ IV PUSH,86140, C REACTIVE PROTEIN,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIRNTL WBC COUNT,9, Consultation GP,0102-100104-1001, SODIUM CHLORIDE & DEXTROSE B.P.

Estimated : Cost

Prescriptions: 0006-106601-0392 - (PARACETAMOL : 500 MG) FILM COATED TABLETS,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,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,0005-252201-0391 - (CAFFEINE : 65 MG) (IBUPROFEN : 400 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 :

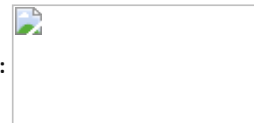
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Sajid Sanaullah

Stamp :



Patient 's signature{Parent : if minor}



Date : 27-Feb-2024

Signature :

Date : 27-Feb-2024