Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **NEEVAN NEWTON FERNANDES**	**Service Date**	**:29-Feb-2024**
Card No	: **I017-029-118947916-01**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	: **NEEVAN NEWTON FERNANDES**	**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	: **27-Jun-2001**		
Patient's Tel No	: **554582536**		

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: Dry cough for the past 2 weeks, Occasionally associated with chest pain, and also gets breathless following bouts of cough. Also worst following vaping. Has a history of asthma as a child. **Duration:**

Vitals: Temp : 37.4 Bp :135 Pulse :96 Resp :22

Clinical Findings:

Diagnosis: J45.991 - Cough variant asthma,J22 - Unspecified acute lower respiratory infection,R07.89 - Other chest pain, **Date of Onset** :29/05/2024

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,85652, SEDIMENTATION RATE RBC AUTOMATED,94640, AIRWAY INHALATION TREATMENT,0188-135906-2441, PULMICORT,0006-402803-2071, VENTOLIN NEBULES,9, Consultation GP **Estimated Cost** :

Prescriptions: 0005-114501-2481 - (AMBROXOL : 15 MG/5ML) SYRUP (SUGAR FREE),0188-272103-0791 - (BUDESONIDE : 160 MCG) (FORMOTEROL FUMARATE : 4.5 MCG) POWDER FOR INHALATION,0195-148602-0391 - (CLARITHROMYCIN : 500 MG) FILM COATED TABLETS,0090-265901-1171 - (MONTELUKAST : 10 MG) TABLETS,0005-119803-1171 - (PREDNISOLONE : 20 MG) 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 : 29-Feb-2024

Signature :

Date : 29-Feb-2024