

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : SAMIR ELSAYED MOHAMED ALI
GOMAA

Card No : I017-029-117981249-02

Policy Holder : SAMIR ELSAYED MOHAMED ALI
GOMAA

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 : 17-Sep-1988

Patient's Tel No : 0528156822

Service Date : 03-Mar-2024

Health Provider : Irham Medical Center Arjan

Doctor's Name : Maimoona

Co-Insurance :

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

Network : Green

Direct Access SP - YES

Remarks :

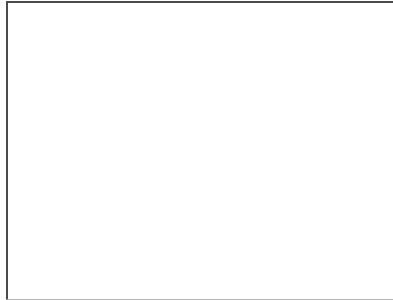
☐ Acute	☐ Pre-existing and chronic	☐ Maternity
Chief Complaints : C/O COUGH ,THROAT PAIN AND FEVER SINCE 6 DAYS PRODUCTIVE COUGH ,MORE AT NIGHT ON EXAMINATION THROAT IS HYPREMIC AND HAVE EXUDATES AND CHEST MILDLY CONGESTED		
Vitals: Temp : 36.5 Bp :99 Pulse :68 Resp :22		
Clinical Findings:		
Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,R05 - Cough,J02.9 - Acute pharyngitis, unspecified,R07.0 - Pain in throat,		Date of Onset :03/34/2024
Requested Investigations: 9, Consultation GP,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,0005-111805-1021, CHLOROHISTOL 10MG-(CHLORPHENIRAMINE MALEATE : 10 MG/ML) SOLUTION FOR INJECTION,96372, THER/PROPH/DIAG INJ SC/IM,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN		Estimated : Cost
Prescriptions: 0006-106601-0392 - (PARACETAMOL : 500 MG) FILM COATED TABLETS, 0195-123701-0391 - (CETIRIZINE HCL : 10 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,0009-127405-0391 - (AZITHROMYCIN : 500 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.

Dr's Name : Maimoona

Stamp :



Signature :



Date : 03-Mar-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 : 03-Mar-2024