Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **SAMIR ELSAYED MOHAMED ALI GOMAA**	**Service Date**	**:03-Mar-2024**	**Network**	: Green
Card No	: **I017-029-117981249-02**	**Health Provider**	**:Irham Medical Center Arjan**	**Direct Access SP - YES**	
Policy Holder	: **SAMIR ELSAYED MOHAMED ALI GOMAA**	**Doctor's Name**	**:Maimoona**		
Payer Name	: **ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**				
TPA	: **E CARE - Green Network**				
Validity	: **01-10-2023** To **30-09-2024**				
Gender	: **Male**	**Remarks**	:		
Date Of Birth	: **17-Sep-1988**				
Patient's Tel No	: **0528156822**				

Co-Insurance :

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 ,THROAT PAIN AND FEVER SINCE 6 DAYS PRODUCTIVE COUGH ,MORE AT NIGHT ON EXAMINATION THROAT IS HYPREMIC AND HAVE EXUDATES AND CHEST MILDLY CONGESTED **Duration:**

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