Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: JEEVAN JOSEPH**	**Service Date**	**:09-Mar-2024**	**Network**	**:** Green
Card No	**: I017-029-119959938-01**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	**: JEEVAN JOSEPH**	**Doctor's Name**	**:Enomen Goodluck**		
Payer Name	**: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:		
TPA	**: E CARE - Green Network**	**Remarks**	**:**		
Validity	**: 01-01-1900** To **30-09-2024**				
Gender	**: Male**				
Date Of Birth	**: 09-Mar-2000**				
Patient's Tel No	**: +919605611892**				

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: Fever since this morning (39 degrees at home). Slight cough, upper epigastric pain and low back pain. **Duration:**

Vitals: Temp : 36.8 Bp :122 Pulse :82 Resp :22

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,R50.9 - Fever, unspecified,A49.9 - Bacterial infection, unspecified, **Date of Onset** **:**09/43/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 1204-571401-1161 - (GUAIFENESIN : 100 MG/5ML) (PSEUDOEPHEDRINE HCL : 30 MG/5ML) (TRIPROLIDINE HCL : 1.25 MG/5ML) SYRUP,0139-116207-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 500 MG) TABLETS,1516-107902-1171 - (IBUPROFEN : 400 MG) TABLETS,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,0252-185801-0391 - (DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS,

Estimated Cost :

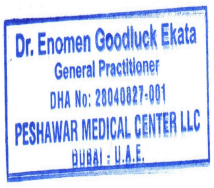
MEDICAL PRACTITIONER DECLARATION :

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.

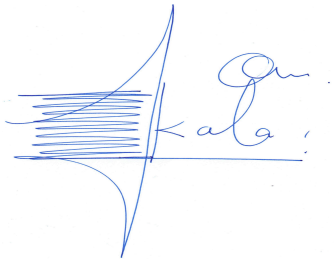
Dr's Name : Enomen Goodluck **Stamp :**



Patient 's signature{Parent if minor} :

Date : 09-Mar-2024

Signature :



Date : 09-Mar-2024