Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: JEEVAN JOSEPH	**Service Date**	:11-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**	:Maimoona		
Payer Name	: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC	**Co-Insurance**	:		

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

TPA	: E CARE - Green Network
Validity	: 01-01-1900 To 30-09-2024
Gender	: Male
Date Of Birth	: 09-Mar-2000
Patient's Tel No	: +919605611892

Remarks :

☐ **Acute** ☐ **Pre-existing and chronic** ☐ **Maternity**

Chief Complaints : c/o fever ,body pain and throat pain since 3 days not getting relieved through oral medicines **Duration:**

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

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,J03.90 - Acute tonsillitis, unspecified,R52 - Pain, unspecified,R50.9 - Fever, unspecified, **Date of Onset** :11/16/2024

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,0195-107704-0801, CEFTRIAXONE-TABUK IV-(CEFTRIAXONE : 1 G) POWDER FOR INJECTION,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,96365, THER/PROPH/DIAG IV INF INIT,96374, THER/PROPH/DIAG INJ IV PUSH,9.01, Follow Up Consultation GP **Estimated Cost** :

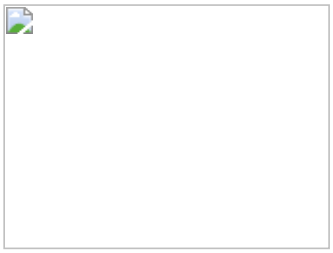
Prescriptions: 0139-116207-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 500 MG) TABLETS, **Estimated Cost** :

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.

Dr's Name : Maimoona **Stamp :**

Signature :



Date : 11-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 : 11-Mar-2024