Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **SUBHAJIT PAUL SAMIR PAUL**	**Service Date**	**:15-Mar-2024**	**Network**	: Green
Card No	: **I017-029-117408282-02**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	: **SUBHAJIT PAUL SAMIR PAUL**	**Doctor's Name**	**:Enomen Goodluck**		
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	: **29-Jan-1992**				
Patient's Tel No	: **521587871**				

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: High grade fever that is worst at night. Pain in throat and difficulty swallowing with headache and cough. **Duration:**

Vitals: Temp : 38.5 Bp :121 Pulse :92 Resp :22

Clinical Findings:

Diagnosis: J03.90 - Acute tonsillitis, unspecified,J02.8 - Acute pharyngitis due to other specified organisms,A49.9 - Bacterial infection, unspecified,R50.9 - Fever, unspecified, **Date of Onset** :15/56/2024

Requested Investigations: 9, Consultation GP,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,96365, THER/PROPH/DIAG IV INF INIT,0195-107704-0801, CEFTRIAXONE-TABUK IV,96372, THER/PROPH/DIAG INJ SC/IM,0005-149902-1021, CLOFEN ,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,96374, THER/PROPH/DIAG INJ IV PUSH **Estimated Cost** :

Prescriptions: 1111-183202-0391 - (FEXOFENADINE HCL : 180 MG) FILM COATED TABLETS,0139-116206-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS,4874-125821-3801 - (POVIDONE IODINE : 0.45%) SPRAY SOLUTION,1516-107902-1171 - (IBUPROFEN : 400 MG) 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 :**

Dr. Enomen Goodluck Ekata
General Practitioner
DHA No: 20040827-001
PESHAWAR MEDICAL CENTER LLC
DUBAI : U.A.E.

Patient 's signature{Parent : if minor} **Date :** 15-Mar-2024

Signature : **Date** : 15-Mar-2024