Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **Ali Nasir Nasir Mahmood Butt**	**Service Date**	**:26-Mar-2024**
Card No	: **I017-029-120505814-01**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	: **Ali Nasir Nasir Mahmood Butt**	**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	: **07-Oct-2002**		
Patient's Tel No	: **0522068560**		

Network : Green

Direct Access SP - YES

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 : Fever and vomiting, and generalized body pain, since this morning. Pain in throat, cough **Duration:**

Vitals: Temp : 36.6 Bp :113 Pulse :82 Resp :16

Clinical Findings:

Diagnosis: J02.9 - Acute pharyngitis, unspecified,J03.90 - Acute tonsillitis, unspecified,R11.10 - Vomiting, unspecified,R50.9 - Fever, unspecified,K29.00 - Acute gastritis without bleeding, **Date of Onset** :26/53/2024

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,9, Consultation GP **Estimated Cost** :

Prescriptions: 0137-242801-0341 - (PANTOPRAZOLE (AS SODIUM) : 20 MG) ENTERIC COATED TABLETS,0005-116801-2481 - (SODIUM CITRATE : 57 MG/5ML) (AMMONIUM CHLORIDE : 131.5 MG/5 ML) (MENTHOL : 1.1 MG/5 ML) (DIPHENHYDRAMINE : 13.5 MG/5ML) SYRUP (SUGAR FREE),2027-560101-0392 - (IBUPROFEN : 150 MG) (PARACETAMOL : 500 MG) FILM COATED TABLETS,0097-127405-0391 - (AZITHROMYCIN : 500 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.

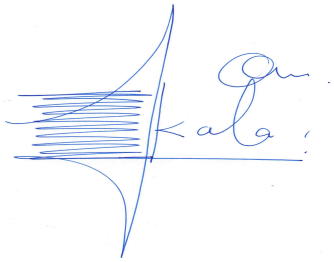
Dr's Name : Enomen Goodluck

Stamp :

Patient 's signature{Parent if minor} :

Date : 26-Mar-2024

Signature :



Date : 26-Mar-2024