Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: HARRISON HENRY MATHOS**	**Service Date**	**:28-Mar-2024**	**Network**	**: Green**
Card No	**: I017-029-116122361-02**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	**: HARRISON HENRY MATHOS**	**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	**: 01-Jan-1994**				
Patient's Tel No	**: 971-52-7929476**				

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: nasal congestion, fever, sorethroat and headache, symptoms since 5days now. Has been on self medications and fever has resolved, but still has body pains and pain in throat and nasal congestion. Has no other medical condition of note, not hypertensive and not diabetic. **Duration:**

Vitals: Temp : 36.9 Bp :137 Pulse :81 Resp :0

Clinical Findings:

Diagnosis: J02.8 - Acute pharyngitis due to other specified organisms,J03.90 - Acute tonsillitis, unspecified,J00 - Acute nasopharyngitis [common cold],J30.9 - Allergic rhinitis, unspecified, **Date of Onset** :28/28/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0097-127405-0391 - (AZITHROMYCIN : 500 MG) FILM COATED TABLETS,0027-128802-2021 - (XYLOMETAZOLINE HYDROCHLORIDE : 0.1%) NASAL DROPS,1516-107902-1171 - (IBUPROFEN : 400 MG) TABLETS,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,0252-389802-1171 - (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE HCL : 30 MG) TABLETS, **Estimated Cost** :

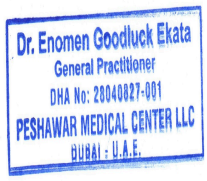
MEDICAL PRACTITIONER DECLARATION :

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.

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.

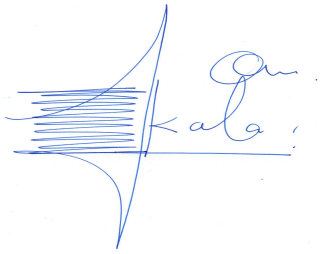
Dr's Name : Enomen Goodluck **Stamp :**



Patient 's signature{Parent : if minor}

Date : 28-Mar-2024

Signature :



Date : 28-Mar-2024