Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **SHUBHAM YADAV TAHASELDAR YADAV**	**Service Date**	**:01-Apr-2024**
Card No	: **I017-029-117490819-02**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	: **SHUBHAM YADAV TAHASELDAR YADAV**	**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	: **28-Sep-1997**		
Patient's Tel No	: **0589532040**		

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 : Nasal congestion, pain in throat, and there is no cough. ALso has generalized body pains and feels tire.d **Duration:**

Vitals: Temp : 36.8 Bp :119 Pulse :86 Resp :22

Clinical Findings:

Diagnosis: J00 - Acute nasopharyngitis [common cold],J02.8 - Acute pharyngitis due to other specified organisms,J03.80 - Acute tonsillitis due to other specified organisms,J30.9 - Allergic rhinitis, unspecified, **Date of Onset** :01/04/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0027-128802-2021 - (XYLOMETAZOLINE HYDROCHLORIDE : 0.1%) NASAL DROPS,0097-127405-0391 - (AZITHROMYCIN : 500 MG) FILM COATED TABLETS,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,1516-107902-1171 - (IBUPROFEN : 400 MG) TABLETS,0252-185801-0391 - (DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS,5363-393801-1161 - (DIPHENHYDRAMINE HCL : 13.5 MG/5ML) (AMMONIUM CHLORIDE : 131.5 MG/5 ML) SYRUP, **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 : Enomen Goodluck

Stamp :

Dr. Enomen Goodluck Ekata
General Practitioner
DHA No: 28040827-001
PESHAWAR MEDICAL CENTER LLC
DUBAI - U.A.E.

Signature :

Date : 01-Apr-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 : 01-Apr-2024