Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: RAGEESH MOOKKICHANKANDI KACHAMBRON DINESHAN KARAI CHAKYATH**	**Service Date**	**:04-Apr-2024**	**Network**	**: Green**
Card No	**: I017-029-116954337-02**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	**: RAGEESH MOOKKICHANKANDI KACHAMBRON DINESHAN KARAI CHAKYATH**	**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	**: 09-Mar-1997**				
Patient's Tel No	**: 0586816074**				

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 : Cold, fever, sneezing, cough productive of yellow sputum, and myalgia. **Duration :**

Vitals: Temp : 36.4 Bp :126 Pulse :78 Resp :18

Clinical Findings:

Diagnosis: J22 - Unspecified acute lower respiratory infection,J00 - Acute nasopharyngitis [common cold],R50.81 - Fever presenting with conditions classified elsewhere,J30.9 - Allergic rhinitis, unspecified, **Date of Onset** :04/57/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0005-114501-2481 - (AMBROXOL : 15 MG/5ML) SYRUP (SUGAR FREE),0027-128802-2021 - (XYLOMETAZOLINE HYDROCHLORIDE : 0.1%) NASAL DROPS,0139-116207-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 500 MG) TABLETS,2027-560101-0392 - (IBUPROFEN : 150 MG) (PARACETAMOL : 500 MG) FILM COATED TABLETS,0195-123701-0391 - (CETIRIZINE HCL : 10 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.

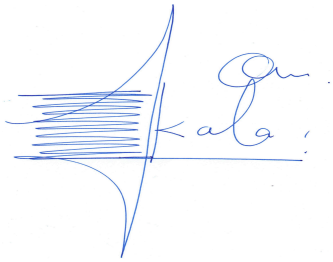
Dr's Name : Enomen Goodluck

Stamp :

Patient 's signature{Parent if minor} :

Date : 04-Apr-2024

Signature :



Date : 04-Apr-2024