Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: JANE NANDIWAYA**	**Service Date**	**:06-Apr-2024**
Card No	**: I017-029-117428434-02**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	**: JANE NANDIWAYA**	**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	**: Female**		
Date Of Birth	**: 21-Feb-1994**		
Patient's Tel No	**: 0526210336**		

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 : **Duration :**

Vitals: Temp : 36.7 Bp :120 Pulse :84 Resp :20

Clinical Findings:

Diagnosis: J02.8 - Acute pharyngitis due to other specified organisms,J03.80 - Acute tonsillitis due to other specified organisms,R05 - Cough, **Date of Onset** :06/39/2024

Requested Investigations: 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,9, Consultation GP,96374, THER/PROPH/DIAG INJ IV PUSH **Estimated Cost :**

Prescriptions: 0005-119805-1172 - (PREDNISOLONE : 5 MG) TABLETS,0202-112001-1161 - (CHLORPHENIRAMINE : 2 MG/5ML) (PSEUDOEPHEDRINE : 30 MG/5ML) SYRUP,6534-101502-0271 - (ACETYLCYSTEINE : 600 MG) EFFERVESCENT TABLETS,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM 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), **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.

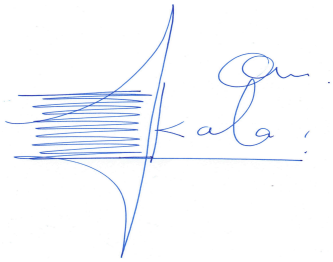
Dr's Name : Enomen Goodluck

Stamp :

Patient 's signature{Parent if minor} :

Date : 06-Apr-2024

Signature :



Date : 06-Apr-2024