Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **ANJUM UZ ZAMAN MUHAMMAD AKRAM MUHAMMAD AKRAM**	**Service Date**	**:06-Apr-2024**
Card No	: **I017-029-119379225-01**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	: **ANJUM UZ ZAMAN MUHAMMAD AKRAM MUHAMMAD AKRAM**	**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	: **02-Dec-1978**		
Patient's Tel No	: **0563233076**		

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 : C/o: Pain in throat, headache, and nasal congestion and low grade fever since yesterday. He is a known diabetic but not hypertensive. **Duration:**

Vitals: Temp : 37 Bp :132 Pulse :90 Resp :22

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,J02.8 - Acute pharyngitis due to other specified organisms,J03.00 - Acute streptococcal tonsillitis, unspecified,R50.9 - Fever, unspecified, **Date of Onset** :06/51/2024

Requested Investigations: 96372, THER/PROPH/DIAG INJ SC/IM,0005-149902-1021, CLOFEN ,9, Consultation GP **Estimated Cost** :

Prescriptions: 1516-107902-1171 - (IBUPROFEN : 400 MG) TABLETS,0027-128802-2021 - (XYLOMETAZOLINE HYDROCHLORIDE : 0.1%) NASAL DROPS,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,0027-265802-1161 - (BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V) SYRUP,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.

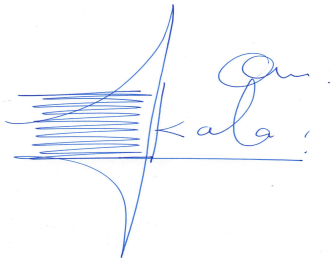
Dr's Name : Enomen Goodluck

Stamp :

Patient 's signature{Parent if minor} :

Date : 06-Apr-2024

Signature :



Date : 06-Apr-2024