Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: CHAN THAR WIN	**Service Date**	:07-Apr-2024	**Network**	: Green
Card No	: I017-029-118780637-01	**Health Provider**	:Irham Medical Center Arjan		**Direct Access SP - YES**
Policy Holder	: CHAN THAR WIN	**Doctor's Name**	:Sajid Sanaullah		
Payer Name	: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC	**Co-Insurance**	:		

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

TPA	: E CARE - Green Network	**Remarks**	:
Validity	: 01-10-2023 To 30-09-2024		
Gender	: Male		
Date Of Birth	: 23-Nov-2002		
Patient's Tel No	: 0589232011		

☐ **Acute** ☐ **Pre-existing and chronic** ☐ **Maternity**

Chief Complaints : fever and swit from 5 days ago **Duration :**

Vitals: Temp : 36.5 Bp :120 Pulse :82 Resp :22

Clinical Findings:

Diagnosis: M79.10 - Myalgia, unspecified site,R53.83 - Other fatigue,A01.00 - Typhoid fever, unspecified,A02.8 - Other specified salmonella infections,R50.9 - Fever, unspecified, **Date of Onset** :07/20/2024

Requested Investigations: 86768, ANTIBODY SALMONELLA,9, Consultation GP,9.01, Follow Up Consultation GP **Estimated Cost :**

Prescriptions: **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 : Sajid Sanaullah **Stamp :**

Dr. Sajid Sanaullah Khan
General Practitioner
DHA No: 05758224-001
PESHAWAR MEDICAL CENTER LLC
DUBAI - U.A.E.

Patient 's signature{Parent if minor} : **Date :** 07-Apr-2024

Signature :  **Date** : 07-Apr-2024