Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: HASAN MOHD HAYATH**	**Service Date**	**:13-Apr-2024**
Card No	**: I017-029-119768244-01**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	**: HASAN MOHD HAYATH**	**Doctor's Name**	**:SANDIA**
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	**: 15-Mar-2000**		
Patient's Tel No	**: +97470826887**		

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 : Pt comes with complain of cold, cough since 9 days fever on and off body pain, cough is productive, no pain in throat headache comes with fever **Duration:**

Vitals: Temp : 37.5 Bp :105 Pulse :75 Resp :20

Clinical Findings:

Diagnosis: R50.9 - Fever, unspecified,J06.9 - Acute upper respiratory infection, unspecified, **Date of Onset** :13/28/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP,86140, C REACTIVE PROTEIN

Prescriptions: 0788-368201-0391 - (PHENYLEPHRINE : 5MG) (GUAIFENESIN : 100 MG) (PARACETAMOL : 250 MG) FILM COATED TABLETS,0009-114501-1161 - (AMBROXOL : 15 MG/5ML) 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.

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.

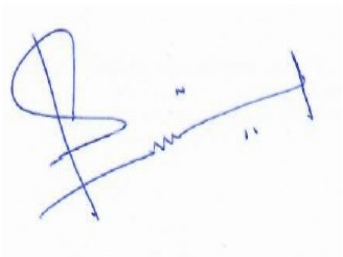
Dr's Name : SANDIA

Stamp :

Patient 's signature{Parent if minor} :

Date : 13-Apr-2024

Signature :



Date : 13-Apr-2024