Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **RAJU GURRAM MUTHYAM REDDY GURRAM**	**Service Date**	**:15-Apr-2024**	**Network**	: Green
Card No	: **I017-029-118947909-01**	**Health Provider**	**:Irham Medical Center Arjan**	**Direct Access SP - YES**	
Policy Holder	: **RAJU GURRAM MUTHYAM REDDY GURRAM**	**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	: **14-Jul-1994**				
Patient's Tel No	: **971566442706**				

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 : feels vomiting on drinking water, patient looks unwell and dehydrated, sore throat on examination throat is red and inflamed tender throat, patient has fever cough cold blocked nose back pain and neck pain **Duration:**

Vitals: Temp : 38.5 Bp :127 Pulse :88 Resp :18

Clinical Findings:

Diagnosis: R50.9 - Fever, unspecified,R05 - Cough,J06.9 - Acute upper respiratory infection, unspecified,J02.9 - Acute pharyngitis, unspecified,M54.5 - Low back pain, **Date of Onset** :15/31/2024

Requested Investigations: 9, Consultation GP,2040-106618-1001, PARACETAMOL S.A.L.F (PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,96365, THER/PROPH/DIAG IV INF INIT,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,96374, THER/PROPH/DIAG INJ IV PUSH **Estimated Cost** :

Prescriptions: 1401-442001-2481 - (AMBROXOL HCL : 30 MG/5ML) SYRUP (SUGAR FREE),4075-819901-1171 - (AZITHROMYCIN DIHYDRATE : 500 MG) TABLETS,0005-252201-0391 - (CAFFEINE : 65 MG) (IBUPROFEN : 400 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 : SANDIA

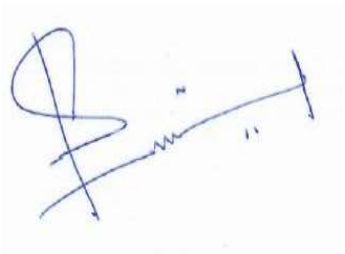
Stamp :

Dr. Sandia Bhojwani
General Practitioner
DHA No: 65900212-001
PESHAWAR MEDICAL CENTER LLC
DUBAI - U.A.E.

Patient 's signature{Parent : if minor}

Date : 15-Apr-2024

Signature :



Date : 15-Apr-2024