Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **DEVA GANESH PALLIROGI VENKATA NARAYANA PALLIROGI**	**Service Date**	**:21-Apr-2024**	**Network**	: Green
Card No	: **I017-029-118993194-01**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	: **DEVA GANESH PALLIROGI VENKATA NARAYANA PALLIROGI**	**Doctor's Name**	**:Sajid Sanaullah**		
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	: **01-Jul-1988**				
Patient's Tel No	: **0558775495**				

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 : co running nose 3days headache 3 days fever 2 days chest congestion bodyache oe ill looking weak high grade fever chest congsted nasal blokage enlarge and inflamed tonsills **Duration:**

Vitals: Temp : 39.7 Bp :124 Pulse :114 Resp :18

Clinical Findings:

Diagnosis: J03.90 - Acute tonsillitis, unspecified,J06.9 - Acute upper respiratory infection, unspecified,R50.9 - Fever, unspecified,J30.9 - Allergic rhinitis, unspecified,R53.1 - Weakness, **Date of Onset** :21/28/2024

Requested Investigations: 2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,0195-107704-0801, CEFTRIAXONE-TABUK IV-(CEFTRIAXONE : 1 G) POWDER FOR INJECTION,9, Consultation GP,0006-402803-2071, VENTOLIN NEBULES,96365, THER/PROPH/DIAG IV INF INIT,94640, AIRWAY INHALATION TREATMENT **Estimated Cost** :

Prescriptions: 0005-119805-1173 - (PREDNISOLONE : 5 MG) TABLETS,0139-116206-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS,0195-123701-0391 - (CETIRIZINE HCL : 10 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 : 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 :** 21-Apr-2024

Signature :  **Date** : 21-Apr-2024