Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: DEVA GANESH PALLIROGI VENKATA NARAYANA PALLIROGI**	**Service Date**	**:23-Apr-2024**
Card No	**: I017-029-118993194-01**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	**: DEVA GANESH PALLIROGI VENKATA NARAYANA PALLIROGI**	**Doctor's Name**	**:Humaira**
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**		

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 : co nasal blockage 7 days running nose 3 days fever on and off 7 days weakness 7 days oe chest is clear no added sounds loooking illl and weak **Duration:**

Vitals: Temp : 37.1 Bp :123 Pulse :85 Resp :18

Clinical Findings:

Diagnosis: J34.89 - Other specified disorders of nose and nasal sinuses,J06.9 - Acute upper respiratory infection, unspecified,R50.9 - Fever, unspecified,R53.1 - Weakness, **Date of Onset** :23/19/2024

Requested Investigations: 9.01, Follow Up Consultation GP,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,85652, SEDIMENTATION RATE RBC AUTOMATED,86140, C REACTIVE PROTEIN,86750, ANTIBODY PLASMODIUM MALARIA,0195-107704-0802, CEFTRIAXONE-TABUK IM-(CEFTRIAXONE : 1 G) POWDER FOR INJECTION,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,0006-402803-2071, VENTOLIN NEBULES-(SALBUTAMOL : 5 MG/2.5ML) NEBULIZING SOLUTION,96372, THER/PROPH/DIAG INJ SC/IM,94640, AIRWAY INHALATION TREATMENT **Estimated Cost :**

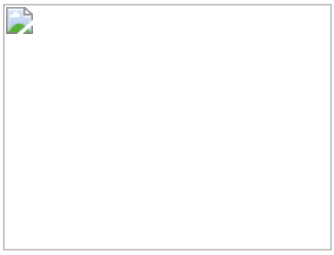
Prescriptions: 0095-238001-0171 - (DICLOFENAC ACID : 46.5MG) DISPERSIBLE TABLETS, **Estimated Cost :**

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 : Humaira **Stamp :** 

Patient 's signature{Parent : if minor}  **Date :** 23-Apr-2024

Signature :  **Date :** 23-Apr-2024