Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: PETER GITAHI MBURU**	**Service Date**	**:30-Apr-2024**
Card No	**: I017-029-119384583-01**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	**: PETER GITAHI MBURU**	**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	**: 24-Sep-1997**		
Patient's Tel No	**: 971566442706**		

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 blood is coming from the nose 1 day before chest pain bodyache oe chest **Duration:**
is clear no added sounds vitals stable

Vitals: Temp : 36.4 Bp :125 Pulse :68 Resp :22

Clinical Findings:

Diagnosis: R04.0 - Epistaxis,R52 - Pain, unspecified,R07.9 - Chest pain, unspecified, **Date of Onset** :30/10/2024

Requested Investigations: 0195-107704-0801, CEFTRIAXONE-TABUK IV,86140, C REACTIVE PROTEIN,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,85652, SEDIMENTATION RATE RBC AUTOMATED,9, Consultation GP,96365, THER/PROPH/DIAG IV INF INIT **Estimated Cost :**

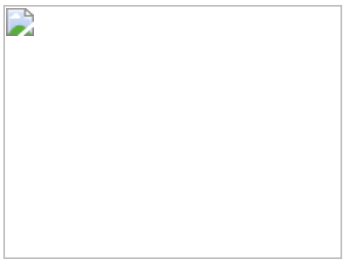
Prescriptions: 7020-992801-1171 - (VITAMIN D (AS CHOLECALCIFEROL) : 5 MCG) (VITAMIN B12 : 2.4 MCG) (BETA CAROTENE : 1740 MCG) (MOLYBDENUM : 23 MCG) (VITAMIN C (ASCORBIC ACID) : 45 MG) (IODINE : 33 MCG) (IRON : 3.5 MG) (THIAMINE : 1.2 MG) (ZINC : 7 MG) (SELENIUM : 20 MCG) (MANGANESE : 1.8 MG) (MAGNESIUM : 120 MG) (BIOTIN : 30 MCG) (RIBOFLAVIN : 1.3 MG) (FOLIC ACID : 200 MCG) (CALCIUM : 250 MG) (VITAMIN K1 : 30 MCG) (CHROMIUM : 25 MCG) (COPPER : 0.45 MG) (PANTOTHENIC ACID : 5 MG) (VITAMIN B6 : 1.3 MG) (VITAMIN E : 4.5 MG) (NIACIN,0724-107002-1171 - (CAFFEINE : 60 MG) (PARACETAMOL : 500 MG) TABLETS,0139-116206-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) 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 :** 30-Apr-2024

Signature :  **Date :** 30-Apr-2024