

Administrative

Patient Name

: NIKHIL ROY KODALI
PORINCHU RAPPAL

Card No

: I017-029-119828392-01

Policy Holder

: NIKHIL ROY KODALI
PORINCHU RAPPAL

Payer Name

: ABU DHABI NATIONAL
INSURANCE COMPANY-
ADNIC

TPA

: E CARE - Green Network

Validity

: 01-10-2023 To 30-09-2024

Gender

: Male

Date Of Birth

: 10-Mar-1999

Patient's Tel No

: 0521663649

Service Date

:01-May-2024

Health Provider

:Irham Medical Center Arjan

Doctor's Name

:Humaira

Co-Insurance

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

Network

: Green

Direct Access SP - YES

☐ Acute

☐ Pre-existing and chronic

☐ Maternity

Chief Complaints : co fever flu cold sneezinmg running nose oe chest is congested no added sounds vitals stabl dehydrated

Duration:

Vitals:Temp : 37.4 Bp :101 Pulse :84 Resp :22

Clinical Findings:

Diagnosis: R50.9 - Fever, unspecified,J30.9 - Allergic rhinitis, unspecified,J06.9 - Acute upper respiratory infection, unspecified,

Date of Onset :01/15/2024

Requested Investigations: 0195-107704-0801, CEFTRIAXONE-TABUK IV,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,85652, SEDIMENTATION RATE RBC AUTOMATED,86140, C REACTIVE PROTEIN,96365, THER/PROPH/DIAG IV INF INIT,96374, THER/PROPH/DIAG INJ IV PUSH,9, Consultation GP

Estimated : Cost

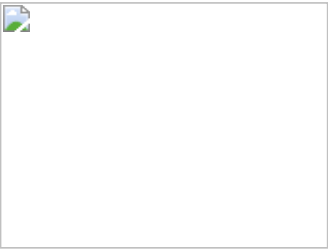
Prescriptions: 0097-393801-2471 - (AMMONIUM CHLORIDE : 131.5 MG/5 ML) (DIPHENHYDRAMINE HCL : 13.5 MG/5ML) SYRUP (ALCOHOL FREE),0005-107001-0051 - (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,0139-116206-1171 - (CLAVULANIC ACID : 125 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.

Dr's Name : Humaira

Stamp : 

Signature : 

Date : 01-May-2024

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.

Patient 's signature{Parent : if minor}



01-May-2024

https://irhamc.visionsoftwares.ae/mr_ecare_claim_print.aspx?appld=47916&patld=51198

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