Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: PRINCE AMAR SINGH**	**Service Date**	**:02-May-2024**	**Network**	**:** Green
Card No	**: I017-029-118921925-01**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	**: PRINCE AMAR SINGH**	**Doctor's Name**	**:SANDIA**		
Payer Name	**: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:		
TPA	**: E CARE - Blue Network**	**Remarks**	:		
Validity	**: 01-10-2023** To **30-09-2024**				
Gender	**: Male**				
Date Of Birth	**: 07-Dec-1992**				
Patient's Tel No	**: 0569488659**				

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 : patient comes with fever since yesterday cold and cough pain in throat headache body ache weakness on examination throat is inflamed and tonsils are enlarged chest is clear **Duration:**

Vitals: Temp : 38.1 Bp :103 Pulse :104 Resp :22

Clinical Findings:

Diagnosis: R50.9 - Fever, unspecified,R05 - Cough,M79.10 - Myalgia, unspecified site,R51.9 - Headache, unspecified,J03.90 - Acute tonsillitis, unspecified, **Date of Onset** :02/57/2024

Requested Investigations: 0005-150403-1021, PREMOSAN -(METOCLOPRAMIDE : 10 MG/2ML) SOLUTION FOR INJECTION,0102-111908-1001, SODIUM CHLORIDE B.P.-(SODIUM CHLORIDE : 0.9% W/V) SOLUTION FOR INFUSION,96374, THER/PROPH/DIAG INJ IV PUSH,9, Consultation GP,85027, BLOOD COUNT COMPLETE AUTOMATED,85651, SEDIMENTATION RATE RBC NON AUTOMATED,86140, C REACTIVE PROTEIN **Estimated Cost :**

Prescriptions: 0097-127405-0391 - (AZITHROMYCIN : 500 MG) FILM COATED TABLETS,0005-114501-2481 - (AMBROXOL : 15 MG/5ML) SYRUP (SUGAR FREE),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.

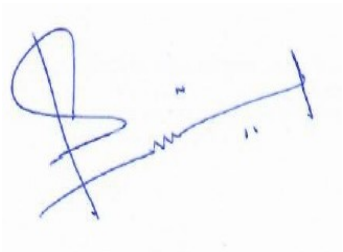
Dr's Name : SANDIA

Stamp :

Patient 's signature{Parent : if minor}

Date : 02-May-2024

Signature :



Date : 02-May-2024