

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : MAHESH RIJAL BINOD KUMAR RIJAL
 Card No : I017-029-117246737-02
 Policy Holder : MAHESH RIJAL BINOD KUMAR RIJAL

Payer Name : ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC

TPA : E CARE - Green Network
 Validity : 01-01-1900 To 30-09-2024
 Gender : Male
 Date Of Birth : 07-Oct-1999
 Patient's Tel No : 0564673569

Service Date : 25-Oct-2023

Network : Green

Health Provider : Irham Medical Center Arjan
 Doctor's Name : Sajid Sanaullah

Direct Access SP - YES

Co-Insurance :

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

Remarks :

☐ Acute ☐ Pre-existing and chronic ☐ Maternity

Chief Complaints : pain in right upper chest difficulty breathing, vomiting in morning decreased urination pain in right upper abdomen O/E tenderness right lower abdomen and upper abdomen
Duration: Throat NAD Chest : Bilateral air entry present

Vitals: Temp : 36.8 Bp :122 Pulse :82 Resp :20

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified, R09.1 - Pleurisy, R11.10 - Vomiting, unspecified, R81 - Glycosuria, N20.0 - Calculus of kidney, J45.991 - Cough variant asthma, M25.511 - Pain in right shoulder, A49.9 - Bacterial infection, unspecified, **Date of Onset** : 25/12/2023

Requested Investigations: 9, Consultation GP, 96365, THER/PROPH/DIAG IV INF INIT, 0005-149902-1021, CLOFEN - (DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION, 94640, AIRWAY INHALATION TREATMENT, 0188-135906-2441, PULMICORT, 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIRNTL WBC COUNT, 86140, C REACTIVE PROTEIN, 81015, URINALYSIS MICROSCOPIC ONLY, 82947, GLUCOSE QUANTITATIVE BLOOD XCPT REAGENT STRIP **Estimated Cost** :

Prescriptions: 0195-149907-0612 - (DICLOFENAC SODIUM : 75 MG) MODIFIED RELEASE CAPSULES, 0541-180401-0431 - (KETOPROFEN : 2.5%) GEL, **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 :

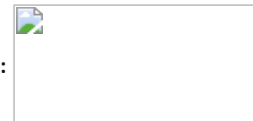
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Sajid Sanaullah

Stamp :



Patient's signature (Parent : if minor)



Date : 25-Oct-2023

Signature :

Date : 25-Oct-2023