Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **MAHESH RIJAL BINOD KUMAR RIJAL**	**Service Date**	**:25-Oct-2023**	**Network**	: Green
Card No	: **I017-029-117246737-02**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	: **MAHESH RIJAL BINOD KUMAR RIJAL**	**Doctor's Name**	**:Sajid Sanaullah**		
Payer Name	: **ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:		
TPA	: **E CARE - Green Network**	**Remarks**	:		
Validity	: **01-01-1900** To **30-09-2024**				
Gender	: **Male**				
Date Of Birth	: **07-Oct-1999**				
Patient's Tel No	: **0564673569**				

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 : 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 Throat NAD Chest : Bilateral air entry present **Duration:**

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 DIFRNTL 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