

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : KHARAK SINGH KISHAN SINGH
Card No : I017-029-119076401-01
Policy Holder : KHARAK SINGH KISHAN SINGH
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 : 15-Jul-1998
Patient's Tel No : 0569469783

Service Date : 08-Dec-2023
Health Provider : Irham Medical Center Arjan
Doctor's Name : Sajid Sanaullah
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

Remarks :

☐ Acute
 ☐ Pre-existing and chronic
 ☐ Maternity

Chief Complaints : Severe sore throat and fever and chills and vomiting and nausea started three days back on 5/12/2023 severe stomach pain started yesterday

Vitals: Temp : 37.5 Bp :124 Pulse :85 Resp :22

Clinical Findings:

Diagnosis: R07.0 - Pain in throat,R05 - Cough,K29.00 - Acute gastritis without bleeding,J02.9 - Acute pharyngitis, Date of Onset :08/53/2023 unspecified,

Requested Investigations: 0102-100104-1001, SODIUM CHLORIDE & DEXTROSE B.P.,0195-107704-0801, CEFTRIAXONE-TABUK IV,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,0005-242802-0781, PANTONIX 40MG I.V.,0005-150403-1021, PREMOSAN ,96360, HYDRATION IV INFUSION INIT,96374, THER/PROPH/DIAG INJ IV PUSH,94640, AIRWAY INHALATION TREATMENT,0188-135906-2441, PULMICORT,0006-124513-2071, VENTOLIN NEBULES,9.01, Follow Up Consultation GP

Estimated : Cost

Prescriptions: 0031-168201-0391 - (DOMPERIDONE : 10 MG) FILM COATED TABLETS,0252-389802-1171 - (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE HCL : 30 MG) TABLETS,0005-116801-1161 - (SODIUM CITRATE : 57 MG/5ML) (AMMONIUM CHLORIDE : 131.5 MG/5 ML) (MENTHOL : 1.1 MG/5 ML) (DIPHENHYDRAMINE : 13.5 MG/5ML) SYRUP,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 :

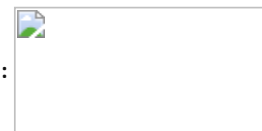
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Sajid Sanaullah

Stamp :



Patient's signature{Parent : if minor}



Date : Dec-2023

Signature :

Date : 08-Dec-2023