Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **MOHSIN KHAN MOHAMMED NIYAZ**	**Service Date**	**:02-May-2024**	**Network**	: Green
Card No	: **I017-029-117360009-02**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	: **MOHSIN KHAN MOHAMMED NIYAZ**	**Doctor's Name**	**:Humaira**		
Payer Name	: **ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:		
TPA	: **E CARE - Green Network**	**Remarks**	:		
Validity	: **01-10-2023** To **30-09-2024**				
Gender	: **Male**				
Date Of Birth	: **01-Sep-1982**				
Patient's Tel No	: **0589929842**				

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 : follow upco fungal infaction on both foot 5 days itching on both feet oe chest **Duration:**
clear vitals stable

Vitals: Temp : 36.7 Bp :114 Pulse :74 Resp :0

Clinical Findings:

Diagnosis: T78.40XS - Allergy, unspecified, sequela,L29.9 - Pruritus, unspecified, **Date of Onset** :02/57/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0027-109206-0151 - (TERBINAFINE (AS HCL) : 1%) CREAM,7048-140201-0061 - (FLUCONAZOLE : 150 MG) CAPSULES,

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** : 02-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} **Date :** 02-May-2024