

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name

: MAJEED MASIH SARDAR MASIH

Card No

: I017-029-116125749-02

Policy Holder

: MAJEED MASIH SARDAR MASIH

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

: 03-Jan-1966

Patient's Tel No

: 0505140326

Service Date

:10-May-2024

Health Provider

:Irham Medical Center Arjan

Doctor's Name

:Humaira

Co-Insurance

Remarks

:

Network

: Green

Direct Access SP - YES

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

: Known hypertensive and diabetic and hyperlipidemia. .Also has a history of chronic gastritis. co body ache joint pain oe swellon leg painful 15 days chest is clear vitals stable

Vitals:Temp

: 37 Bp :134 Pulse :74 Resp :20

Clinical Findings:

Diagnosis:

E78.2 - Mixed hyperlipidemia,I10 - Essential (primary) hypertension,M25.579 - Pain in unspecified ankle and joints of unspecified foot,

Requested Investigations:

80061, LIPID PANEL,84550, URIC ACID BLOOD,82947, GLUCOSE QUANTITATIVE BLOOD XCPT REAGENT STRIP,9, Consultation GP

Estimated Cost

:

Prescriptions:

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.

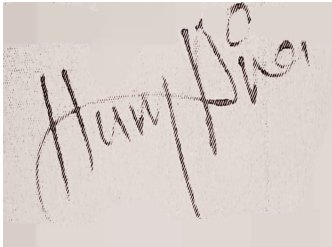
Dr's Name

: Humaira

Stamp :

Dr. Humaira Mumtaz
General Practitioner
DHA No: 54155530-002
PESHAWAR MEDICAL CENTER LLC
DUBAI - U.A.E.

Signature :



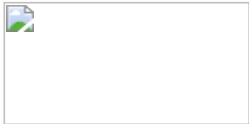
Date

: 10-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

: May-2024