Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **ASFAK KHAN IBRAHIM KHAN**	**Service Date**	**:14-May-2024**
Card No	: **I017-029-118394174-02**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	: **ASFAK KHAN IBRAHIM KHAN**	**Doctor's Name**	**:SANDIA**
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-Jan-1995**		
Patient's Tel No	: **0523650862**		

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 : pt had fever 3 days ago now have no fever but feel body pain and and rashes on body started yesterday morning. on exam chest is clear throat is fine **Duration:**

Vitals: Temp : 36 Bp :129 Pulse :75 Resp :18

Clinical Findings:

Diagnosis: R21 - Rash and other nonspecific skin eruption,R53.1 - Weakness,T78.49XA - Other allergy, initial encounter, **Date of Onset** :14/16/2024

Requested Investigations: 9, Consultation GP,96372, THER/PROPH/DIAG INJ SC/IM,0005-111805-1021, CHLOROHISTOL 10MG **Estimated Cost** :

Prescriptions: 0006-106601-0394 - (PARACETAMOL : 500 MG) FILM COATED TABLETS,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS, **Estimated Cost** :

MEDICAL PRACTITIONER DECLARATION :

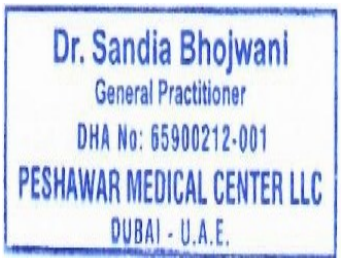
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

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 : SANDIA

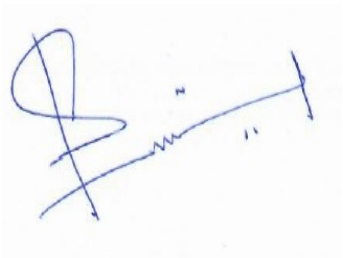
Stamp :



Patient 's signature{Parent if minor} :

Date : 14-May-2024

Signature :



Date : 14-May-2024