

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : Anjali Lama
Card No : I017-029-120175024-01
Policy Holder : Anjali Lama
Payer Name : ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC
TPA : E CARE - Green Network
Validity : 01-10-2023 To 30-09-2024
Gender : Female
Date Of Birth : 23-Jan-1998
Patient's Tel No : 0507823227

Service Date : 17-May-2024
Health Provider : Irham Medical Center Arjan
Doctor's Name : Enomen Goodluck
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 headache, pain radiates to the back of the neck, it is located on both sides of the skull. Also has fever and generalized body pains, and has nausea but has not vomited. Declined investigations and perenteral treatment.

Vitals: Temp : 37.5 Bp :116 Pulse :78 Resp :18

Clinical Findings:

Diagnosis: G43.019 - Migraine w/o aura, intractable, without status migrainosus, R51.9 - Headache, unspecified, **Date of Onset**: 17/51/2024

Requested Investigations: 9, Consultation GP
Estimated Cost :

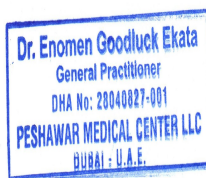
Prescriptions: 0027-142201-0832 - (DICLOFENAC POTASSIUM : 50 MG) POWDER FOR SOLUTION, 0006-199803-1171 - (SUMATRIPTAN : 100 MG) TABLETS,
Estimated Cost :

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.

Dr's Name : Enomen Goodluck

Stamp :



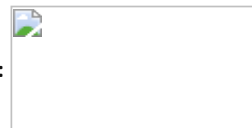
Signature :

Date : 17-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}



17-
Date : May-2024