

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name: RAMI SAMIR KAMAL ABDELAZIZ

Card No: I017-029-116591803-02

Policy Holder: RAMI SAMIR KAMAL ABDELAZIZ

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: 22-Jan-1985

Patient's Tel No: 0527640808

Service Date: 18-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: Frequent passage of urine for the past one week. Visits the washroom on the average about 17 times per day. Also has nocturia which has made him unable to sleep at night. He is a known hypertensive but not previously diabetic. Both parents are hypertensive and diabetic (very strong first degree association). FBS yesterday was 449mg/dl (as seen on his report). RBS at presentation this morning is 597mg/dl. Patient is counselled on lifestyle and dietary modification. For rehydration. Consider referral for expert management

Duration:

Vitals:Temp : 37.2 Bp :131 Pulse :89 Resp :0

Clinical Findings:

Diagnosis: E11.65 - Type 2 diabetes mellitus with hyperglycemia,E08.65 - Diabetes due to underlying condition w hyperglycemia,J02.9 - Acute pharyngitis, unspecified,R50.9 - Fever, unspecified,

Date of Onset: 18/43/2024

Requested Investigations: 96360, HYDRATION IV INFUSION INIT,0102-111908-1001, SODIUM CHLORIDE B.P.,0195-107704-0801, CEFTRIAXONE-TABUK IV,9.01, Follow Up Consultation GP,96374, THER/PROPH/DIAG INJ IV PUSH

Estimated Cost:

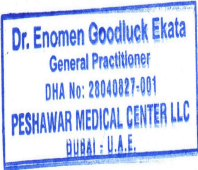
Prescriptions: 0252-185801-0391 - (DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS,0090-204902-0391 - (SITAGLIPTIN (AS PHOSPHATE) : 50 MG) (METFORMIN HCL : 500 MG) FILM COATED TABLETS,

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.

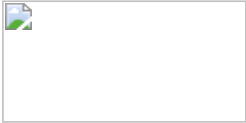
Dr's Name: Enomen Goodluck

Stamp: 

Signature: 

Date: 18-May-2024

Patient's signature(Parent : if minor)



Date: May-2024

https://irhamc.visionsoftw ares.ae/mr_ecare_claim_print.aspx?appld=48311&patId=52275

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