Administrative **MEDICAL CLAIM FORM** **Claim Ref:**

Patient Name	: John Viannie Kajjoba	**Service Date**	:21-May-2024	**Network**	: Green
Card No	: I017-029-114165333-02	**Health Provider**	:Irham Medical Center Arjan		**Direct Access SP - YES**
Policy Holder	: John Viannie Kajjoba	**Doctor's Name**	:Enomen Goodluck		
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	: 30-Jul-1980				
Patient's Tel No	: 0522262866				

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 : **Duration :**

Vitals:

Clinical Findings:

Diagnosis: I30.9 - Acute pericarditis, unspecified,K29.00 - Acute gastritis without bleeding,R07.9 - Chest pain, unspecified, **Date of Onset** :21/25/2024

Requested Investigations: 9.01, Follow Up Consultation GP,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,96372, THER/PROPH/DIAG INJ SC/IM,0005-136504-1021, SCOPINAL-(HYOSCINE : 20 MG/ML) SOLUTION FOR INJECTION,96374, THER/PROPH/DIAG INJ IV PUSH,0005-242802-0781, PANTONIX 40MG I.V.-(PANTOPRAZOLE (AS SODIUM) : 40 MG) POWDER FOR INFUSION,96365, THER/PROPH/DIAG IV INF INIT **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.

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 :**

Dr. Enomen Goodluck Ekata
General Practitioner
DHA No: 28040827-001
PESHAWAR MEDICAL CENTER LLC
DUBAI : U.A.E.

Patient 's signature{Parent if minor} : **Date :** 21-May-2024

Signature : **Date** : 21-May-2024