Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: JEEVAN JOSEPH**	**Service Date**	**:23-May-2024**
Card No	**: I017-029-119959938-01**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	**: JEEVAN JOSEPH**	**Doctor's Name**	**:Enomen Goodluck**
Payer Name	**: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	**:**
TPA	**: E CARE - Green Network**	**Remarks**	**:**
Validity	**: 01-01-1900** To **30-09-2024**		
Gender	**: Male**		
Date Of Birth	**: 09-Mar-2000**		
Patient's Tel No	**: +919605611892**		

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 : Pain in the right shoulder joint following a mild trauma. Said to have bit hit while unloading a package. Exam: slight swelling at the acromioclavicular joint area, no diformity and no limitation of movement. **Duration:**

Vitals: Temp : 36.9 Bp :141 Pulse :76 Resp :20

Clinical Findings:

Diagnosis: M25.511 - Pain in right shoulder, **Date of Onset** : 23/00/2024

Requested Investigations: 9, Consultation GP **Estimated Cost** :

Prescriptions: **Estimated Cost** :

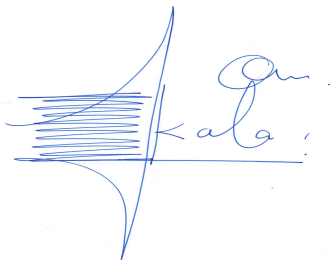
MEDICAL PRACTITIONER DECLARATION :

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 : 23-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 : 23-May-2024