Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **Caleb Musyoki Nzengula**	**Service Date**	:**24-May-2024**	**Network**	: Green
Card No	: **I017-029-116122171-02**	**Health Provider**	:**Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	: **Caleb Musyoki Nzengula**	**Doctor's Name**	:**Humaira**		
Payer Name	: **ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:		

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

TPA	: **E CARE - Green Network**	**Remarks**	:
Validity	: **01-10-2023** To **30-09-2024**		
Gender	: **Male**		
Date Of Birth	: **15-Aug-1988**		
Patient's Tel No	: **0559096728**		

☐ **Acute** ☐ **Pre-existing and chronic** ☐ **Maternity**

Chief Complaints : **Duration :**

Vitals:

Clinical Findings:

Diagnosis: R73.9 - Hyperglycemia, unspecified,E86.0 - Dehydration,R63.1 - Polydipsia, **Date of Onset** :24/27/2024

Requested Investigations: 9.01, Follow Up Consultation GP,82947, GLUCOSE QUANTITATIVE BLOOD XCPT REAGENT STRIP **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.

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 : Humaira

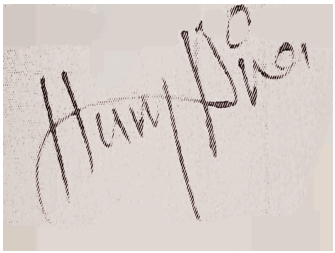
Stamp :

Dr. Humaira Mumtaz
General Practitioner
DHA No: 54155530-002
PESHAWAR MEDICAL CENTER LLC
DUBAI - U.A.E.

Patient 's signature{Parent if minor} :

Date : 24-May-2024

Signature :



Date : 24-May-2024