Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: SONAM TAMANG**	**Service Date**	**:28-May-2024**
Card No	**: I017-029-120831151-01**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	**: SONAM TAMANG**	**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	**: 11-Mar-1999**		
Patient's Tel No	**: 0563505195**		

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

Network : Green

Direct Access SP - YES

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

Chief Complaints : Rashes on the right side of the neck. it is itchy,. **Duration :**

Vitals: Temp : 36.7 Bp :108 Pulse :68 Resp :18

Clinical Findings:

Diagnosis: L30.9 - Dermatitis, unspecified,L20.9 - Atopic dermatitis, unspecified, **Date of Onset** :28/24/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0070-148701-1171 - (LORATADINE : 10 MG) TABLETS,0031-124403-0151 - (MOMETASONE FUROATE : 0.1%) CREAM,

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.

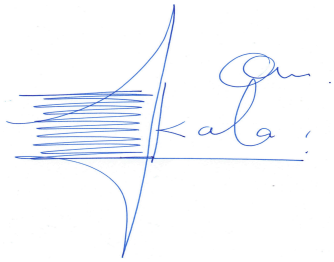
PATIENT'S DECLARATION :

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 :**

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 :** 28-May-2024

Signature :  **Date** : 28-May-2024