Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: AGGREY ONYANGO**	**Service Date**	**:03-Jun-2024**	**Network**	: Green
Card No	**: I017-029-116125957-02**	**Health Provider**	**:Irham Medical Center Arjan**	**Direct Access SP - YES**	
Policy Holder	**: AGGREY ONYANGO**	**Doctor's Name**	**:Enomen Goodluck**		
Payer Name	**: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:		
TPA	**: ECARE-EBP EBP Enhanced CLASIC**	**Remarks**	**:**		
Validity	**: 01-10-2023** To **30-09-2024**				
Gender	**: Male**				
Date Of Birth	**: 12-Nov-1983**				
Patient's Tel No	**: 0543892858**				

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 : For follow up **Duration :**

Vitals: Temp : 36.7 Bp :153 Pulse :63 Resp :18

Clinical Findings:

Diagnosis: J02.9 - Acute pharyngitis, unspecified,I10 - Essential (primary) hypertension, **Date of Onset** :04/50/2024

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.

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 :** 04-Jun-2024

Signature : **Date** : 04-Jun-2024