Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **MAZHAR HANIF MUHAMMAD HANIF**	**Service Date**	**:04-Jun-2024**
Card No	: **I017-029-114504364-02**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	: **MAZHAR HANIF MUHAMMAD HANIF**	**Doctor's Name**	**:Humaira**
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	: **07-Oct-1987**		
Patient's Tel No	: **0551120684**		

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 : **Duration :**

Vitals:

Clinical Findings:

Diagnosis: R23.1 - Pallor,R53.1 - Weakness,L29.9 - Pruritus, unspecified,R42 - Dizziness and giddiness, **Date of Onset** :04/56/2024

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 : Humaira

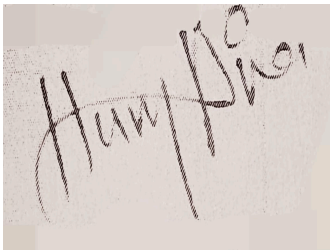
Stamp :

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

Patient 's signature{Parent : if minor}

Date : 04-Jun-2024

Signature :



Date : 04-Jun-2024