Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: NJAU JOEL MUNGAI**	**Service Date**	**:05-Jun-2024**	**Network**	: Green
Card No	**: I017-029-118780384-01**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	**: NJAU JOEL MUNGAI**	**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	**: 17-Jun-1984**				
Patient's Tel No	**: 0526136782**				

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 : C/o: Pain and itching on the interdigital spaces of the toes of the right foot and left foot also. Assessment: Athletes foot. **Duration:**

Vitals: Temp : 36.7 Bp :110 Pulse :84 Resp :18

Clinical Findings:

Diagnosis: B35.3 - Tinea pedis,L29.9 - Pruritus, unspecified, **Date of Onset** : 05/14/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0009-148801-0151 - (KETOCONAZOLE : 2%) CREAM,0031-109204-1172 - (TERBINAFINE (AS HCL) : 250 MG) TABLETS,

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 :**

Dr. Enomen Goodluck Ekata
General Practitioner
DHA No: 28040827-001
PESHAWAR MEDICAL CENTER LLC
DUBAI - U.A.E.

Signature : **Date** : 05-Jun-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 : 05-Jun-2024