

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : Mark Jason Tulabot Singian
Card No : I017-029-113767017-02
Policy Holder : Mark Jason Tulabot Singian
Payer Name : ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC
TPA : E CARE - Green Network
Validity : 01-10-2023 To 30-09-2024
Gender : Male
Date Of Birth : 01-Apr-1998
Patient's Tel No : 0504918225

Service Date : 07-Jun-2024
Health Provider : Irham Medical Center Arjan
Doctor's Name : Enomen Goodluck
Co-Insurance :

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

Network : Green
Direct Access SP - YES
Remarks :

☐ Acute
 ☐ Pre-existing and chronic
 ☐ Maternity

Chief Complaints : PC: Fever since last, generlized body pain.

Duration :

Vitals:Temp : 38.5 Bp :110 Pulse :76 Resp :18

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,N10 - Acute pyelonephritis,M79.10 - Myalgia, Date of :07/06/2024
 unspecified site,K29.00 - Acute gastritis without bleeding,R11.10 - Vomiting, unspecified,R50.9 - Fever, unspecified, Onset

Requested Investigations: 96360, HYDRATION IV INFUSION INIT,0102-100104-1001, SODIUM CHLORIDE & DEXTROSE B.P.-(SODIUM CHLORIDE : 0.9%) (DEXTROSE : 5%) SOLUTION FOR INFUSION,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,9, Consultation GP,96365, THER/PROPH/DIAG IV INF INIT

Estimated :
Cost

Prescriptions: 0252-185801-0391 - (DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS,2027-560101-0392 - (IBUPROFEN : 150 MG) (PARACETAMOL : 500 MG) FILM COATED TABLETS,0054-103201-0391 - (CIPROFLOXACIN : 500 MG) FILM COATED TABLETS,

Estimated :
Cost

MEDICAL PRACTITIONER DECLARATION :

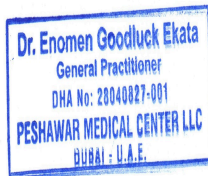
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

PATIENT'S DECLARATION :

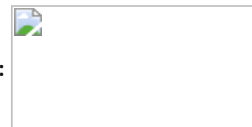
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Enomen Goodluck

Stamp :



Patient 's signature{Parent : if minor}



07-
Date : Jun-
 2024

Signature :

Date : 07-Jun-2024