Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: YAM RAJ GIRI**	**Service Date**	**:10-Jun-2024**	**Network**	: Green
Card No	**: I017-029-116653001-02**	**Health Provider**	**:Irham Medical Center Arjan**	**Direct Access SP - YES**	
Policy Holder	**: YAM RAJ GIRI**	**Doctor's Name**	**:Enomen Goodluck**		
Payer Name	**: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:		
TPA	**: E CARE - Green Network**	**Remarks**	:		
Validity	**: 01-01-1900** To **30-09-2024**				
Gender	**: Male**				
Date Of Birth	**: 01-Jan-1991**				
Patient's Tel No	**: 54381867448787800**				

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 : High grade fever since yesterday (09/06/2024). Diarrhea since this morning for which he has had over 6 episodes. Previously visited another clinic this morning but no respite. Abdomen: no abnormality detected. **Duration:**

Vitals:

Clinical Findings:

Diagnosis: A09 - Infectious gastroenteritis and colitis, unspecified,R50.9 - Fever, unspecified,R19.7 - Diarrhea, unspecified, **Date of Onset** :10/31/2024

Requested Investigations: 0102-152902-1001, LACTATED RINGERS INJECTION USP,96360, HYDRATION IV INFUSION INIT,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,0005-136504-1021, SCOPINAL,0005-149902-1021, CLOFEN ,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,0005-242802-0781, PANTONIX 40MG I.V.,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP,30042033, CIPROFLOXACIN,0002-116601-1001, METRONIDAZOLE : 500 MG/100ML) SOLUTION FOR INFUSION **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 :** 10-Jun-2024

Signature : **Date** : 10-Jun-2024