Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: MANJU LAMA**	**Service Date**	**:13-Jun-2024**	**Network**	**: Green**
Card No	**: I017-029-120125902-01**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	**: MANJU LAMA**	**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	**: Female**				
Date Of Birth	**: 26-Nov-1987**				
Patient's Tel No	**: 0504625016**				

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: Temp : 37.8 Bp :120 Pulse :76 Resp :18

Clinical Findings:

Diagnosis: M13.0 - Polyarthritis, unspecified,R50.9 - Fever, unspecified,R52 - Pain, unspecified,D50.9 - Iron deficiency anemia, unspecified, **Date of Onset** :13/14/2024

Requested Investigations: 9, Consultation GP,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,96372, THER/PROPH/DIAG INJ SC/IM,0005-149902-1021, CLOFEN ,96365, IV INFUSION THERAPY -Antibiotics & Others,0320-107701-0801, CEBACT ,(CEFTRIAXONE : 1000 MG) POWDER FOR INJECTION ,0102-111908-1001, SODIUM CHLORIDE B.P.,0002-116601-1001, METRONIDAZOLE : 500 MG/100ML) SOLUTION FOR INFUSION ,83020, HEMOGLOBIN FRACTJ/QUANTJ ELECTROPHORESIS,83540, IRON,86038, ANTINUCLEAR ANTIBODIES ANA **Estimated Cost :**

Prescriptions: 0252-182103-0081 - (IRON (AS FERRIC/FERROUS HYDROXIDE POLYMALTOSE COMPLEX) : 100 MG) CHEWABLE TABLETS,0097-116206-0391 - (AMOXICILLIN : 875 MG) (CLAVULANIC ACID : 125 MG) FILM COATED TABLETS,1516-107902-1171 - (IBUPROFEN : 400 MG) TABLETS,0005-119803-1171 - (PREDNISOLONE : 20 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.

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 :** 13-Jun-2024

Signature : **Date** : 13-Jun-2024