Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **SHUBHAM YADAV TAHASELDAR YADAV**	**Service Date**	**:20-Jun-2024**
Card No	: **I017-029-117490819-02**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	: **SHUBHAM YADAV TAHASELDAR YADAV**	**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	: **28-Sep-1997**		
Patient's Tel No	: **0589532040**		

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 : Pain and swelling in the left axilla Duration: 3days. there is no fever **Duration :**

Vitals: Temp : 36.5 Bp :127 Pulse :74 Resp :18

Clinical Findings:

Diagnosis: L02.422 - Furuncle of left axilla,R52 - Pain, unspecified, **Date of Onset** : 20/08/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 6960-116403-0061 - (AMOXICILLIN : 500 MG) CAPSULES,0027-142201-2401 - (DICLOFENAC POTASSIUM : 50 MG) SUGAR 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 :**

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** : 20-Jun-2024

Signature : **Date** : 20-Jun-2024