

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : RUBIN MAHARJAN
Card No : I017-029-117174621-02
Policy Holder : RUBIN MAHARJAN
Payer Name : ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC
TPA : E CARE - Blue Network
Validity : 01-10-2023 To 30-09-2024
Gender : Male
Date Of Birth : 26-Jun-1998
Patient's Tel No : 0588812699

Service Date : 21-Oct-2023
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 : Pain on both ears, with associated reduced hearing on the right. Also has fever for the past two days with pain in throat. ENT: Right ear packed full with wax; TM not visualized. Left ear: TM visualized, however, mild inflammation noted. Throat shows hyperemia

Vitals: Temp : 36.4 Bp :120 Pulse :78 Resp :22

Clinical Findings:

Diagnosis: H90.2 - Conductive hearing loss, unspecified, H61.21 - Impacted cerumen, right ear, H60.8X2 - Other otitis externa, left ear, H92.02 - Otalgia, left ear, J02.9 - Acute pharyngitis, unspecified, R07.0 - Pain in throat,

Date of Onset : 21/29/2023

Requested Investigations: 69210, RMVL IMPACTED CERUMEN SPX 1/BOTH EARS, 9, Consultation GP, 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT

Estimated Cost :

Prescriptions: 0355-103204-1681 - (CIPROFLOXACIN : 0.3%) EYE / EAR DROPS, 2027-560101-0392 - (IBUPROFEN : 150 MG) (PARACETAMOL : 500 MG) FILM COATED TABLETS, 0252-185801-0391 - (DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS,

Estimated Cost :

MEDICAL PRACTITIONER DECLARATION :

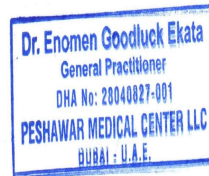
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

PATIENT'S DECLARATION :

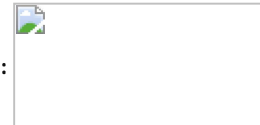
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Enomen Goodluck

Stamp :



Patient's signature {Parent if minor} :



21-
Date : Oct-2023

Signature :

Date : 21-Oct-2023