Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **RAGEESH MOOKKICHANKANDI KACHAMBRON DINESHAN KARAI CHAKYATH**	**Service Date**	**:22-Oct-2023**	**Network**	: Green
Card No	: **I017-029-116954337-02**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	: **RAGEESH MOOKKICHANKANDI KACHAMBRON DINESHAN KARAI CHAKYATH**	**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	: **Male**				
Date Of Birth	: **09-Mar-1997**				
Patient's Tel No	: **0586816074**				

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 : injury to the left hand. Said to have mistakenly cut his hand while trying to open a can of food with a knife. Injury: Clean laceration, measures 6cm in length. **Duration:**

Vitals: Temp : 37.2 Bp :145 Pulse :95 Resp :22

Clinical Findings:

Diagnosis: S61.412A - Laceration without foreign body of left hand, init encntr,G89.11 - Acute pain due to trauma, **Date of Onset:**22/46/2023

Requested Investigations: 9, Consultation GP,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,96372, THER/PROPH/DIAG INJ SC/IM,0005-149902-1021, CLOFEN ,SUTURE MEDIUM, SUTURE MEDIUM **Estimated Cost** :

Prescriptions: 0290-106307-0081 - (ASCORBIC ACID (VITAMIN C) : 100 MG) CHEWABLE TABLETS,0139-116403-1451 - (AMOXICILLIN : 500 MG) CAPSULES (HARD GELATIN),2027-560101-0392 - (IBUPROFEN : 150 MG) (PARACETAMOL : 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.

Dr's Name : Enomen Goodluck **Stamp :**

Dr. Enomen Goodluck Ekata
General Practitioner
DHA No: 20040827-001
PESHAWAR MEDICAL CENTER LLC
DUBAI : U.A.E.

Signature : **Date** : 22-Oct-2023

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.

Patient 's signature{Parent : if minor} **Date :** 22-Oct-2023