

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : STANLEY MUIRURI WANJIRU

Card No : I017-029-116954338-02

Policy Holder : STANLEY MUIRURI WANJIRU

Payer Name : ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC

TPA : E CARE - Green Network

Validity : 01-10-2023 To 30-09-2024

Gender : Male

Date Of Birth : 25-Oct-1988

Patient's Tel No : 0569493860

Service Date : 23-Oct-2023

Health Provider : Irham Medical Center Arjan

Doctor's Name : Sajid Sanaullah

Co-Insurance :

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

Remarks :

Network : Green

Direct Access SP - YES

☐ Acute

☐ Pre-existing and chronic

☐ Maternity

Chief Complaints : PT PRESENTED WITH BLEEDING PER RECTAL OF TWO WEEKS DURATION AGGREGATED SINCE FEW DAYS WAS ASSOCIATED WITH PAIN PS 6/10 HAS BEEN TAKING MEDICATIONS FOR THE PAST FEW DAYS.BUT NO RELIEF NO KNOWN RELIEVING FACTORS HE HAS A FIRST DEGREE HAEMORRHOID

Duration:

Vitals:Temp : 37 Bp :116 Pulse :66 Resp :20

Clinical Findings:

Diagnosis: K64.8 - Other hemorrhoids,R52 - Pain, unspecified,K64.4 - Residual hemorrhoidal skin tags,D64.9 - Anemia, unspecified,

Date of Onset :23/16/2023

Requested Investigations: 9, Consultation GP

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.

Dr's Name : Sajid Sanaullah

Stamp :

Dr. Sajid Sanaullah Khan

General Practitioner

DHA No: 05758224-001

PESHAWAR MEDICAL CENTER LLC

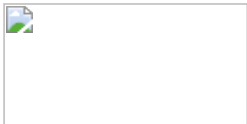
DUBAI - U.A.E.

Signature :

Date : 23-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}



23-
Date : Oct-
2023

https://irhamc.visionsoftw ares.ae/mr_ecare_claim_print.aspx?appld=42232&patId=38479

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