Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **STANLEY MUIRURI WANJIRU**	**Service Date**	**:23-Oct-2023**	**Network**	: Green
Card No	: **I017-029-116954338-02**	**Health Provider**	**:Irham Medical Center Arjan**	**Direct Access SP - YES**	
Policy Holder	: **STANLEY MUIRURI WANJIRU**	**Doctor's Name**	**:Sajid Sanaullah**		
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	: **25-Oct-1988**				
Patient's Tel No	: **0569493860**				

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 : PT PRESENTED WITH BLEEDING PER RECTAL OF TWO WEEKS DURATION AGGREVATED 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.

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 : Sajid Sanaullah **Stamp :**

Dr. Sajid Sanaullah Khan
General Practitioner
DHA No: 05758224-001
PESHAWAR MEDICAL CENTER LLC
DUBAI - U.A.E.

Patient 's signature{Parent : if minor} **Date :** 23-Oct-2023

Signature : **Date** : 23-Oct-2023