

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** : Dr. Hamid Esmaeilpour
Payer Name : ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC **Co-Insurance** :

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

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

☐ Acute ☐ Pre-existing and chronic ☐ Maternity

Chief Complaints : severe rectal bleeding started since 5 days on 18/10/2023 and pain in rectal area **Duration**:

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

Clinical Findings:

Diagnosis: K64.8 - Other hemorrhoids, K51.311 - Ulcerative (chronic) rectosigmoiditis with rectal bleeding, **Date of Onset** : 23/55/2023

Estimated Cost :

Requested Investigations: 10, Consultation Specialist

Prescriptions: 1291-170801-1161 - (LACTULOSE : 66.7%) SYRUP, 0669-242802-3261 - (PANTOPRAZOLE Estimated : (AS SODIUM) : 40 MG) DELAYED RELEASE TABLET, 0138-116604-1171 - (METRONIDAZOLE : 500 MG) Cost TABLETS,

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 :

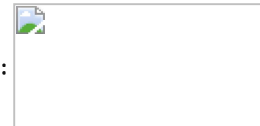
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Dr. Hamid Esmaeilpour

Stamp :



Patient's signature {Parent : if minor}



Date : 23-Oct-2023

Signature :

Date : 23-Oct-2023