# Administrative MEDICAL CLAIM FORM Claim Ref:

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|---|---|---|---|---|---|
| **Patient Name** | **: Sweety Pie Agustin Abellera** | **Service Date** | **:23-Oct-2023** | **Network** | **: Green** |
| **Card No** | **: I017-029-114165338-02** | **Health Provider** | **:Irham Medical Center Arjan** | | **Direct Access SP - YES** |
| **Policy Holder** | **: Sweety Pie Agustin Abellera** | **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** | **: Female** | | | | |
| **Date Of Birth** | **: 21-Nov-1997** | | | | |
| **Patient's Tel No** | **: 0588680668** | | | | |

| 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 :** SWELLING IN THE VAGINA (FURUNCLE?) MILD FEVER NO PAIN TENDERNESS++ BURNING++ REFUSED FOR EXAMINATION SHOWED PICTURE.SWELLING OF 1X1 CM,ERYTHEMA+ **Duration:**

**Vitals:**Temp : 37.3 Bp :1104 Pulse :94 Resp :20

**Clinical Findings:**

**Diagnosis:** R50.9 - Fever, unspecified,K29.00 - Acute gastritis without bleeding,L08.9 - Local infection of the skin and subcutaneous tissue, unsp,L02.225 - Furuncle of perineum, **Date of Onset** :23/28/2023

**Estimated Cost :**

**Requested Investigations:** 9, Consultation GP

**Prescriptions:** 0207-214402-0151 - (BETAMETHASONE : N/A) (CLOTRIMAZOLE : N/A) CREAM,0139-116207-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 500 MG) TABLETS,0005-106601-1171 - (PARACETAMOL : 500 MG) 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** : Sajid Sanaullah

**Stamp :**


**Patient 's signature{Parent if minor} :**

**Date :** 23-Oct-2023

**Signature :**

**Date** : 23-Oct-2023