

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : BALAIAH BANDI
Card No : I017-029-117559344-02
Policy Holder : BALAIAH BANDI
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 : 06-Aug-1988
Patient's Tel No : 0524940307

Service Date : 24-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

Network : Green
Direct Access SP - YES

Remarks :

☐ Acute
 ☐ Pre-existing and chronic
 ☐ Maternity

Chief Complaints : C/o swelling and pain in right elbow after fall at home O/E swelling seen over Duration: extensor of elbow joint, restricted movement Gas

Vitals: Temp : 37 Bp :120 Pulse :90 Resp :20

Clinical Findings:

Diagnosis: M25.521 - Pain in right elbow, M25.421 - Effusion, right elbow, K29.00 - Acute gastritis without bleeding, S59.901A - Unspecified injury of right elbow, initial encounter,
 Date of Onset : 24/31/2023

Requested Investigations: 9, Consultation GP, 96374, THER/PROPH/DIAG INJ IV PUSH, 0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION, 0005-242802-0781, PANTONIX 40MG I.V.-(PANTOPRAZOLE (AS SODIUM) : 40 MG) POWDER FOR INFUSION
 Estimated Cost :

Prescriptions: 0195-149907-0612 - (DICLOFENAC SODIUM : 75 MG) MODIFIED RELEASE CAPSULES,
 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 :

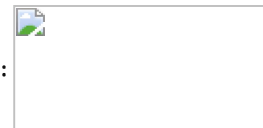
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Sajid Sanaullah

Stamp :



Patient's signature{Parent : if minor}



24-
Date : Oct-2023

Signature :

Date : 24-Oct-2023