Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: SUNITA GAUTAM**	**Service Date**	**:26-Oct-2023**
Card No	**: I017-029-117800348-02**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	**: SUNITA GAUTAM**	**Doctor's Name**	**:Enomen Goodluck**
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	**: 06-Oct-1993**		
Patient's Tel No	**: 0564765991**		

Network : Green

Direct Access SP - YES

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 : Generalized body weakness, lower abdominal pain. symptoms since 2days. periods started 3days ago, a day prior to onset of symptoms (LMP: 23/10/2023). There is no fever, no vomiting, no nausea and no change in bowel habit. Has no respiratory symptoms, **Duration:**

Vitals: Temp : 36.5 Bp :150 Pulse :85 Resp :22

Clinical Findings:

Diagnosis: N94.6 - Dysmenorrhea, unspecified,R10.30 - Lower abdominal pain, unspecified,R53.1 - Weakness,R42 - Dizziness and giddiness, **Date of Onset** :26/49/2023

Requested Investigations: 9, Consultation GP,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN **Estimated Cost** :

Prescriptions: 0252-182201-0081 - (FOLIC ACID : 0.35 MG) (IRON (AS FERRIC/FERROUS HYDROXIDE POLYMALTOSE COMPLEX) : 100 MG) CHEWABLE TABLETS,0067-142201-0391 - (DICLOFENAC POTASSIUM : 50 MG) FILM COATED 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.

Dr's Name : Enomen Goodluck

Stamp :

Dr. Enomen Goodluck Ekata
General Practitioner
DHA No: 28040827-001
PESHAWAR MEDICAL CENTER LLC
DUBAI : U.A.E.

Signature :

Date : 26-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} :

Date : 26-Oct-2023