Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **BIBIN ALIAS ALIAS MATHAIKUDIYIL VARGHESE**	**Service Date**	**:28-Oct-2023**
Card No	: **I017-029-118720586-01**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	: **BIBIN ALIAS ALIAS MATHAIKUDIYIL VARGHESE**	**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	: **07-Sep-1997**		
Patient's Tel No	: **0547455239**		

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 : nail trauma at home when closing the door finger between the metallic door and severe pain and swelling and large hematoma under the nail in right thumb on 28/10/2023 **Duration:**

Vitals: Temp : 37 Bp :114 Pulse :82 Resp :22

Clinical Findings:

Diagnosis: S60.10XA - Contusion of unsp finger with damage to nail, init encntr, **Date of Onset** :28/52/2023

Requested Investigations: 9, Consultation GP,0005-149902-1021, CLOFEN ,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,96372, THER/PROPH/DIAG INJ SC/IM **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 :

Patient 's signature{Parent if minor} :

Date : 28-Oct-2023

Signature :

Date : 28-Oct-2023