Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **BIBIN ALIAS ALIAS MATHAIKUDIYIL VARGHESE**	**Service Date**	:**29-Oct-2023**	**Network**	: Green
Card No	: **I017-029-118720586-01**	**Health Provider**	:**Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	: **BIBIN ALIAS ALIAS MATHAIKUDIYIL VARGHESE**	**Doctor's Name**	:**Dr. Hamid Esmaeilpour**		
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**				

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 : **Duration :**

Vitals:

Clinical Findings:

Diagnosis: **Date of Onset** : 29/10/2023

Requested Investigations: 11765, WEDGE EXCISION SKIN NAIL FOLD,10.01, Follow up Consultation Specialist **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.

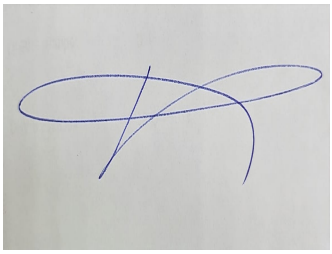
PATIENT'S DECLARATION :

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 : Dr. Hamid Esmaeilpour **Stamp :**

Dr. Hamid Esmaeilpour
Specialist General Surgery
DHA No: 10991334-001
PESHAWAR MEDICAL CENTER LLC
DUBAI - U.A.E.

Patient 's signature{Parent : if minor} **Date :** 29-Oct-2023

Signature :  **Date** : 29-Oct-2023