Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **TANVIBEN SANJAYBHAI PARMAR**	**Service Date**	**:03-Nov-2023**
Card No	: **I017-029-117065774-02**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	: **TANVIBEN SANJAYBHAI PARMAR**	**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	: **28-Mar-1997**		
Patient's Tel No	: **0545775842**		

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 : severe itching and hair falling since one week started and lice seen on the hair **Duration:** started 25/10/2023

Vitals: Temp : 36.7 Bp :83 Pulse :75 Resp :22

Clinical Findings:

Diagnosis: B85.0 - Pediculosis due to Pediculus humanus capitis, **Date of Onset** : 03/13/2023

Requested Investigations: 9, Consultation GP **Estimated Cost** :

Prescriptions: 0314-177001-0921 - (LINDANE (GAMMA BENZENE HEXACHLORIDE) : 1%) (DICOPHANE : 1%) SHAMPOO, **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 : Sajid Sanaullah

Stamp :

Signature :

Date : 03-Nov-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 : 03-Nov-2023