

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : VEERA JYOTHI KUMAR
Card No : THIMMANANA ANANDA RAO THIMMANANA
Policy Holder : I017-029-117673071-02
Payer Name : VEERA JYOTHI KUMAR
TPA : THIMMANANA ANANDA RAO THIMMANANA
Validity : ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC
Gender : E CARE - Green Network
Date Of Birth : 01-10-2023 To 30-09-2024
Patient's Tel No : 07-Aug-2000
Tel No : 0545902559

Service Date : 05-Nov-2023
Health Provider : Irham Medical Center Arjan
Doctor's Name : Enomen Goodluck
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 : For follow up Wound site is swollen, hyperemic and tender. Wound site infection/cellulitis confirmed due to poor wound care Patient also affirmed he did not take medication as prescribed.

Duration:

Vitals:

Clinical Findings:

Diagnosis: S61.412S - Laceration without foreign body of left hand, sequela, L03.114 - Cellulitis of left upper limb, **Date of Onset**: 05/44/2023

Estimated Cost :

Requested Investigations: 9.01, Follow Up Consultation GP, 15850, REMOVAL OF SUTURES

Prescriptions: 0097-116207-0392 - (AMOXICILLIN : 500 MG) (CLAVULANIC ACID : 125 MG) FILM COATED TABLETS,

Estimated Cost :

MEDICAL PRACTITIONER DECLARATION :

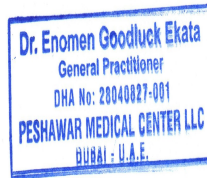
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

PATIENT'S DECLARATION :

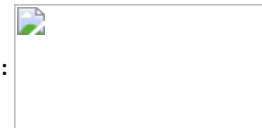
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Enomen Goodluck

Stamp :



Patient's signature {Parent : if minor}



05-
Date : Nov-2023

Signature :

Date : 05-Nov-2023