

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : PRIYANKA CHAMALIE IHALA
Card No : I017-029-118720574-01
Policy Holder : PRIYANKA CHAMALIE IHALA
GEDARA
Payer Name : ABU DHABI NATIONAL
INSURANCE COMPANY-ADNIC
TPA : E CARE - Green Network
Validity : 01-10-2023 To 30-09-2024
Gender : Female
Date Of Birth : 20-Nov-1979
Patient's Tel No : 0509202615

Service Date : 06-Nov-2023
Health Provider : Irham Medical Center Arjan
Doctor's Name : Enomen Goodluck

Network : Green
Direct Access SP - YES

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

Remarks :

☐ Acute	☐ Pre-existing and chronic	☐ Maternity
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Chief Complaints : C/o: Highly pruritic lesion on the neck, right shoulder, abdomen and back. **Duration:**
 Symptom onset since 3months. Exam: Lesion demonstrates an active margin and central clearing.

Vitals: Temp : 36.6 Bp :120 Pulse :76 Resp :20

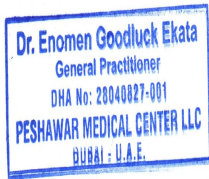
Clinical Findings:

Diagnosis: B35.4 - Tinea corporis, L29.8 - Other pruritus, **Date of Onset :** 06/53/2023

Requested Investigations: 9, Consultation GP,85025, BLOOD COUNT COMPLETE AUTO&AUTO
 DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,86485, SKIN TEST CANDIDA **Estimated Cost :**

Prescriptions: 0252-148701-1172 - (LORATADINE : 10 MG) TABLETS,0078-148801-0151 -
 (KETOCONAZOLE : 2%) CREAM,0027-109204-1171 - (TERBINAFINE (AS HCL) : 250 MG) 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.
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Dr's Name : Enomen Goodluck **Stamp :**


Signature :  **Date :** 06-Nov-2023

Patient's signature{Parent : if minor}  **Date :** 06-Nov-2023