Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **PRIYANKA CHAMALIE IHALA GEDARA**	**Service Date**	**:06-Nov-2023**	**Network**	**:** Green
Card No	: **I017-029-118720574-01**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	: **PRIYANKA CHAMALIE IHALA GEDARA**	**Doctor's Name**	**:Enomen Goodluck**		
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	: **20-Nov-1979**				
Patient's Tel No	: **0509202615**				

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 : C/o: Highly pruritic lesion on the neck, right shoulder, abdomen and back. Symptom onset since 3months. Exam: Lesion demonstrates an active margin and central clearing. **Duration:**

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.

Dr's Name : Enomen Goodluck **Stamp :**

Dr. Enomen Goodluck Ekata
General Practitioner
DHA No: 28040827-001
PESHAWAR MEDICAL CENTER LLC
DUBAI - U.A.E.

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