Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: JAUHARA NAMUKAABYA	**Service Date**	:06-Nov-2023	**Network**	: Green
Card No	: I017-029-116933017-02	**Health Provider**	:Irham Medical Center Arjan		**Direct Access SP - YES**
Policy Holder	: JAUHARA NAMUKAABYA	**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	: 03-Dec-1991				
Patient's Tel No	: 0523593797				

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: Abdominal pain since the past one week. Pain is located at the left side of the abdomen just at the left iliac fossa region. . There is no known relieving nor aggravating symptoms. it is not related to meals. There is no vomiting, no nausea, no change in bowel habit. Has no urinary symptoms, no frequency and no pain on passing urine. There is also no fever. This is the first episode of this kind of pain in her life. LMP: ??/10/2023. (said mid october, date unknown). **Duration:**

Vitals: Temp : 37 Bp :120 Pulse :88 Resp :20

Clinical Findings:

Diagnosis: N83.202 - Unspecified ovarian cyst, left side,R10.30 - Lower abdominal pain, unspecified,R52 - Pain, unspecified, **Date of Onset** :06/02/2023

Requested Investigations: 9, Consultation GP,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,85652, SEDIMENTATION RATE RBC AUTOMATED,81001, URNLS DIP STICK/TABLET REAGENT AUTO MICROSCOPY **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 : Enomen Goodluck **Stamp :** Dr. Enomen Goodluck Ekata General Practitioner DHA No: 28040827-001 PESHAWAR MEDICAL CENTER LLC DUBAI : U.A.E.

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

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