

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : MICHAEL JOHN GAUANG
Card No : I017-029-116125764-02
Policy Holder : MICHAEL JOHN GAUANG
Payer Name : ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC
TPA : E CARE - Green Network
Validity : 01-10-2023 To 30-09-2024
Gender : Male
Date Of Birth : 02-Oct-1988
Patient's Tel No : 0528511028

Service Date : 19-Nov-2023
Health Provider : Irham Medical Center Arjan
Doctor's Name : Sajid Sanaullah

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

Chief Complaints : Severe redness between thighs in private parts started since two days ago on 17/11/2023

Vitals: Temp : 36.5 Bp :126 Pulse :73 Resp :22

Clinical Findings:

Diagnosis: L23.9 - Allergic contact dermatitis, unspecified cause, **Date of Onset :** 19/53/2023

Requested Investigations: 9, Consultation GP,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,0005-111805-1021, CHLOROHISTOL 10MG,96372, THER/PROPH/DIAG INJ SC/IM

Estimated Cost

Prescriptions: 0207-214402-0151 - (BETAMETHASONE : N/A) (CLOTRIMAZOLE : N/A) CREAM,0205-123701-0391 - (CETIRIZINE HCL : 10 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 :

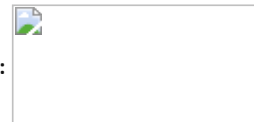
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Sajid Sanaullah

Stamp :



Patient's signature{Parent : if minor}



Date : 19-Nov-2023

Signature :

Date : 19-Nov-2023