Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **MICHAEL JOHN GAUANG DUCAY**	**Service Date**	**:19-Nov-2023**	**Network**	: Green
Card No	: **I017-029-116125764-02**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	: **MICHAEL JOHN GAUANG DUCAY**	**Doctor's Name**	**:Sajid Sanaullah**		
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	: **Male**				
Date Of Birth	: **02-Oct-1988**				
Patient's Tel No	: **0528511028**				

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 : Severe redness between thighs in private parts started since two days ago on**Duration:** 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