Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: JEEVAN JOSEPH	**Service Date**	:22-Nov-2023	**Network**	: Green
Card No	: I017-029-119959938-01	**Health Provider**	:Irham Medical Center Arjan		**Direct Access SP - YES**
Policy Holder	: JEEVAN JOSEPH	**Doctor's Name**	:Sajid Sanaullah		
Payer Name	: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC	**Co-Insurance**	:		
TPA	: E CARE - Green Network	**Remarks**	:		
Validity	: 01-01-1900 To 30-09-2024				
Gender	: Male				
Date Of Birth	: 09-Mar-2000				
Patient's Tel No	: +919605611892				

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 : **Duration :**

Vitals:

Clinical Findings:

Diagnosis: L03.221 - Cellulitis of neck,J18.0 - Bronchopneumonia, unspecified organism, **Date of Onset :**22/45/2023

Requested Investigations: 51.03, Non-surgical cleansing with surgical dressing more than 48 sq inches / 300 sq centimeters,9.01, Follow Up Consultation GP **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 : Sajid Sanaullah

Stamp :

Patient 's signature{Parent if minor} :

Date : 22-Nov-2023

Signature :

Date : 22-Nov-2023