

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : Caleb Musyoki Nzengula

Card No : I017-029-116122171-02

Policy Holder : Caleb Musyoki Nzengula

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 : 15-Aug-1988

Patient's Tel No : 0559096728

Service Date : 24-Nov-2023

Network : Green

Health Provider : Irham Medical Center Arjan

Direct Access SP - YES

Doctor's Name : Sajid Sanaullah

Co-Insurance :

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 : LF leg pain from 3week ago

Duration :

Vitals:Temp : 36.1 Bp :122 Pulse :80 Resp :20

Clinical Findings:

Diagnosis: M06.80 - Other specified rheumatoid arthritis, unspecified site,R53.1 - Weakness,M00.862 - Arthritis due to other bacteria, left knee,M00.861 - Arthritis due to other bacteria, right knee,

Date of Onset : 24/13/2023

Requested Investigations: 9, Consultation GP,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,85652, SEDIMENTATION RATE RBC AUTOMATED,82306, 25 HYDROXY INCLUDES
Estimated Cost

FRACTIONS IF PERFORMED,82310, CALCIUM TOTAL,82330, CALCIUM IONIZED,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,0005-149902-1021, CLOFEN ,84550, URIC ACID BLOOD,96372, THER/PROPH/DIAG INJ SC/IM,96360, HYDRATION IV INFUSION INIT,0102-100104-1001, SODIUM CHLORIDE & DEXTROSE B.P.-(SODIUM CHLORIDE : 0.9%) (DEXTROSE : 5%) SOLUTION FOR INFUSION

Estimated Cost**Prescriptions:****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 :

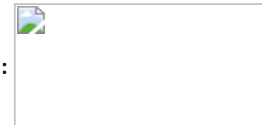
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Sajid Sanaullah

Stamp :



Patient's signature{Parent : if minor}


 24-
Date : Nov-
2023

Signature :

Date : 24-Nov-2023