Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: Caleb Musyoki Nzengula**	**Service Date**	**:24-Nov-2023**	**Network**	**:** Green
Card No	**: I017-029-116122171-02**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	**: Caleb Musyoki Nzengula**	**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	**: 15-Aug-1988**				
Patient's Tel No	**: 0559096728**				

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 : 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 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: **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 : 24-Nov-2023

Signature :

Date : 24-Nov-2023