Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: CHAN THAR WIN**	**Service Date**	**:25-Nov-2023**	**Network**	**: Green**
Card No	**: I017-029-118780637-01**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	**: CHAN THAR WIN**	**Doctor's Name**	**:Enomen Goodluck**		
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	**: 23-Nov-2002**				
Patient's Tel No	**: 0589232011**				

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 : C/o: dry and scaly skin around the neck. also maculopapular rashes on the right shoulder and upper back. **Duration:**

Vitals: Temp : 36.4 Bp :115 Pulse :84 Resp :22

Clinical Findings:

Diagnosis: L30.9 - Dermatitis, unspecified, **Date of Onset** : 25/15/2023

Estimated Cost :

Requested Investigations: 9, Consultation GP

Estimated Cost :

Prescriptions: 0096-130804-0151 - (DEXPANTHANOL : 50 MG/G) CREAM,

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.

Dr's Name : Enomen Goodluck

Stamp : Dr. Enomen Goodluck Ekata, General Practitioner, DHA No: 28040827-001, PESHAWAR MEDICAL CENTER LLC, DUBAI - U.A.E.

Signature :

Date : 25-Nov-2023

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.

Patient 's signature{Parent if minor} :

Date : 25-Nov-2023