Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: KARTHIKRAJA SALAMONDOSS SALAMONDOSS**
Card No	**: I017-029-115434058-02**
Policy Holder	**: KARTHIKRAJA SALAMONDOSS SALAMONDOSS**
Payer Name	**: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**
TPA	**: E CARE - Green Network**
Validity	**: 01-01-1900** To **30-09-2024**
Gender	**: Male**
Date Of Birth	**: 18-Jun-1988**
Patient's Tel No	**: 0559406026**

Service Date **:30-Nov-2023** **Network** **:** Green

Health Provider **:Irham Medical Center Arjan** **Direct Access SP - YES**

Doctor's Name **:Dr. Hamid Esmaeilpour**

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 : face crash yesterday 29/11/2023 **Duration :**

Vitals: Temp : 37 Bp :153 Pulse :74 Resp :22

Clinical Findings:

Diagnosis: Y08.81XS - Assault by crashing of aircraft, sequela,Y32.XXXS - Crashing of motor vehicle, undetermined intent, sequela, **Date of Onset** :30/32/2023

Requested Investigations: 16020, CLEANING AND DRESSING BURNS 1ST/SBSQ SMALL,0195-107704-0801, CEFTRIAXONE-TABUK IV,0102-100104-1001, SODIUM CHLORIDE & DEXTROSE B.P.,96360, HYDRATION IV INFUSION INIT,10, Consultation Specialist **Estimated Cost** :

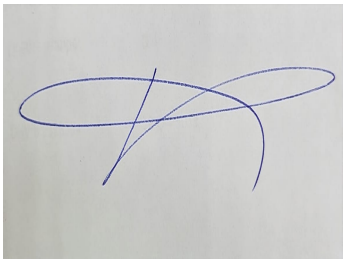
Prescriptions: 6076-482003-0392 - (CIPROFLOXACIN (AS HYDROCHLORIDE) : 500 MG) FILM COATED TABLETS,0631-183502-0151 - (SILVER SULFADIAZINE : 1%) CREAM, **Estimated Cost** :

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.

Dr's Name : Dr. Hamid Esmaeilpour **Stamp :**

Dr. Hamid Esmaeilpour
Specialist General Surgery
DHA No: 10991334-001
PESHAWAR MEDICAL CENTER LLC
DUBAI - U.A.E.

Signature :  **Date** : 30-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 :** 30-Nov-2023