

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 : 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 : 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** :30/26/2023

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, **Estimated Cost** :
 HYDRATION IV INFUSION INIT,9, Consultation GP

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.

PATIENT'S DECLARATION :

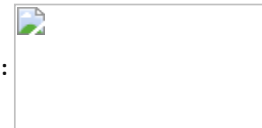
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Sajid Sanaullah

Stamp :



Patient's signature{Parent :
 if minor}



30-
Date : Nov-
 2023

Signature :

Date : 30-Nov-2023