## 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, HYDRATION IV INFUSION INIT,9, Consultation GP **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.

**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 :** 30-Nov-2023

**Signature :**

**Date** : 30-Nov-2023