Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: JEVON PRAISTY PASA**	**Service Date**	**:01-Dec-2023**
Card No	**: I017-029-117698584-02**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	**: JEVON PRAISTY PASA**	**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	**: 25-Dec-1991**		
Patient's Tel No	**: 521718292**		

Network : Green

Direct Access SP - YES

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 : from last night, florigen body in RT ear **Duration :**

Vitals: Temp : 35.9 Bp :122 Pulse :81 Resp :22

Clinical Findings:

Diagnosis: T16.9XXS - Foreign body in ear, unspecified ear, sequela, **Date of Onset :**01/29/2023

Estimated Cost :

Requested Investigations: 9, Consultation GP,10120, REMOVE FOREIGN BODY

Estimated Cost :

Prescriptions:

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 : 01-Dec-2023

Signature :

Date : 01-Dec-2023