

Administrative

MEDICAL CLAIM FORM

Claim Ref:

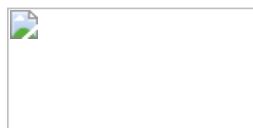
Patient Name : JEVON PRAISTY PASA
Card No : I017-029-117698584-02
Policy Holder : JEVON PRAISTY PASA
Payer Name : ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC
TPA : E CARE - Green Network
Validity : 01-10-2023 To 30-09-2024
Gender : Male
Date Of Birth : 25-Dec-1991
Patient's Tel No : 521718292

Service Date : 01-Dec-2023
Health Provider : Irham Medical Center Arjan
Doctor's Name : Sajid Sanaullah
Co-Insurance :

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

Network : Green
Direct Access SP - YES

Remarks :

☐ Acute	☐ Pre-existing and chronic	☐ Maternity		
Chief Complaints : from last night, foreign 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		
Requested Investigations : 9, Consultation GP,10120, REMOVE FOREIGN BODY		Estimated Cost :		
Prescriptions :				
<table border="0"> <tr> <td> 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. </td> <td> 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. </td> </tr> </table>			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.
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Dr's Name : Sajid Sanaullah	Stamp :	Patient's signature{Parent : if minor}		
Signature :				
Date : 01-Dec-2023		Date : Dec-2023		

