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	**:02-Dec-2023**
Health Provider	**:Irham Medical Center Arjan**
Doctor's Name	**:Sajid Sanaullah**
Co-Insurance	**:**

Network : Green

Direct Access SP - YES

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 : **Duration :**

Vitals: Temp : 36.6 Bp :115 Pulse :78 Resp :19

Clinical Findings:

Diagnosis: S09.8XXD - Other specified injuries of head, subsequent encounter, **Date of Onset** :02/42/2023

Requested Investigations: 9.01, Follow Up Consultation GP,51.01, Non-surgical cleansing with surgical dressing 16 sq inches / 100 sq centimeters or less **Estimated Cost** :

Prescriptions: **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 : 02-Dec-2023

Signature :

Date : 02-Dec-2023