

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 **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 : **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 :

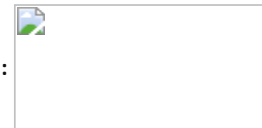
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Sajid Sanaullah

Stamp :



Patient's signature{Parent : if minor}



Date : 02-Dec-2023

Signature :

Date : 02-Dec-2023