Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **ABDUL RAUF REHMAT ULLAH**	**Service Date**	**:02-Dec-2023**
Card No	: **I017-029-115381312-02**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	: **ABDUL RAUF REHMAT ULLAH**	**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	: **01-Jan-1962**		
Patient's Tel No	: **0554356612**		

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 : known hypertensive came for medication refill **Duration :**

Vitals: Temp : 37 Bp :124 Pulse :74 Resp :0

Clinical Findings:

Diagnosis: I10 - Essential (primary) hypertension, **Date of Onset** : 02/24/2023

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0252-186703-0391 - (LOSARTAN POTASSIUM : 100 MG) (HYDROCHLOROTHIAZIDE : 12.5 MG) FILM COATED TABLETS,

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