Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **GRETCHEN CAPANGPANGAN PACARAT**	**Service Date**	**:14-Dec-2023**	**Network**	: Green
Card No	: **I017-029-116280045-02**	**Health Provider**	**:Irham Medical Center Arjan**	**Direct Access SP - YES**	
Policy Holder	: **GRETCHEN CAPANGPANGAN PACARAT**	**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	: **Female**				
Date Of Birth	: **22-Dec-1985**				
Patient's Tel No	: **0545432908**				

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 : FEVER AND ALSO ITCHING AND ALSO HEAD ACHE AND ALSO MUSCULAR PAIN AND ALSO COUGH DRY COUGH **Duration:**

Vitals: Temp : 37.4 Bp :108 Pulse :73 Resp :22

Clinical Findings:

Diagnosis: R51.9 - Headache, unspecified,R50.9 - Fever, unspecified,L29.8 - Other pruritus,R05 - Cough,M79.11 - Myalgia of mastication muscle, **Date of Onset** :14/26/2023

Requested Investigations: 9, Consultation GP **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 :**

Dr. Sajid Sanaullah Khan
General Practitioner
DHA No: 05758224-001
PESHAWAR MEDICAL CENTER LLC
DUBAI - U.A.E.

Patient 's signature{Parent if minor} : **Date** : 14-Dec-2023

Signature :  **Date** : 14-Dec-2023