Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **WAQAR AHMED MOHD ASLAM**	**Service Date**	**:18-Dec-2023**
Card No	: **I017-029-119050823-01**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	: **WAQAR AHMED MOHD ASLAM**	**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	: **15-Jan-1998**		
Patient's Tel No	: **0545734696**		

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 : acnea **Duration :**

Vitals: Temp : 36.7 Bp :108 Pulse :81 Resp :22

Clinical Findings:

Diagnosis: L70.9 - Acne, unspecified,L66.2 - Folliculitis decalvans, **Date of Onset** : 18/01/2023

Requested Investigations: 0195-107704-0802, CEFTRIAXONE-TABUK IM,96372, THER/PROPH/DIAG INJ SC/IM,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,9, Consultation GP,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,85652, SEDIMENTATION RATE RBC AUTOMATED,86140, C REACTIVE PROTEIN,84520, UREA NITROGEN QUANTITATIVE,84295, SODIUM SERUM PLASMA OR WHOLE BLOOD,84132, POTASSIUM SERUM PLASMA/WHOLE BLOOD,84450, TRANSFERASE ASPARTATE AMINO AST SGOT,84460, TRANSFERASE ALANINE AMINO ALT SGPT,84075, PHOSPHATASE ALKALINE **Estimated Cost :**

Prescriptions: 0434-308702-0151 - (HYDROCORTISONE : 10 MG/G) (IODOCHLORHYDROXYQUIN : 30 MG/G) CREAM,0139-128301-0151 - (MUPIROCIN : 2%) CREAM,0195-169101-1451 - (DOXYCYCLINE : 100 MG) CAPSULES (HARD GELATIN), **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 : 18-Dec-2023

Signature :

Date : 18-Dec-2023