Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: TUSHAR TUCARAM CHAWAN TUCARAM CHAWAN**
Card No	**: I017-029-114604753-02**
Policy Holder	**: TUSHAR TUCARAM CHAWAN TUCARAM CHAWAN**
Payer Name	**: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**
TPA	**: E CARE - Green Network**
Validity	**: 01-10-2023** To **30-09-2024**
Gender	**: Male**
Date Of Birth	**: 10-Nov-1993**
Patient's Tel No	**: 0523894803**

Service Date **:18-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 : SEVERE SKIN RASHES IN BOTH TIGHS AND SEVERE ICHING SINCE 11/12/2023 **Duration:**

Vitals: Temp : 36.7 Bp :123 Pulse :61 Resp :22

Clinical Findings:

Diagnosis: T78.40XA - Allergy, unspecified, initial encounter,B35.4 - Tinea corporis, **Date of Onset** :18/36/2023

Requested Investigations: 0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,0005-111805-1021, CHLOROHISTOL 10MG,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP **Estimated Cost** :

Prescriptions: 1729-528901-0152 - (CALAMINE : 4 G/100G) (ZINC (AS ZINC OXIDE) : 3 G/100G) CREAM,0207-214402-0151 - (BETAMETHASONE : N/A) (CLOTRIMAZOLE : N/A) CREAM,0205-123701-0391 - (CETIRIZINE HCL : 10 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 : 18-Dec-2023

Signature :

Date : 18-Dec-2023