Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **SAMIR ELSAYED MOHAMED ALI GOMAA**	**Service Date**	**:16-Jan-2024**	**Network**	: Green
Card No	: **I017-029-117981249-02**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	: **SAMIR ELSAYED MOHAMED ALI GOMAA**	**Doctor's Name**	**:Sajid Sanaullah**		
Payer Name	: **ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:		
TPA	: **E CARE - Green Network**	**Remarks**	:		
Validity	: **01-01-1900** To **30-09-2024**				
Gender	: **Male**				
Date Of Birth	: **17-Sep-1988**				
Patient's Tel No	: **0528156822**				

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 : C/O PAIN AND PIMPLE IN LEFT AXILLA , PAINFUL ON TOUCH , SINCE 5 DAYS ON EXAMINATION PATIENT HAS SWELLING OF ALMOST 6CM IN AXILLARY AREA ,NOT ASSOCIATED WITH DISCHARGE OR OOZING AND TENDER TO TOUCH **Duration:**

Vitals: Temp : 36.6 Bp :113 Pulse :88 Resp :22

Clinical Findings:

Diagnosis: L02.432 - Carbuncle of left axilla,R22.9 - Localized swelling, mass and lump, unspecified,L02.411 - Cutaneous abscess of right axilla, **Date of Onset** :16/59/2024

Requested Investigations: 0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,96374, THER/PROPH/DIAG INJ IV PUSH,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,85651, SEDIMENTATION RATE RBC NON AUTOMATED,9, Consultation GP **Estimated Cost** :

Prescriptions: 0005-101701-0391 - (ACECLOFENAC : 100 MG) FILM COATED TABLETS,0669-242802-3261 - (PANTOPRAZOLE (AS SODIUM) : 40 MG) DELAYED RELEASE TABLET,0097-116206-0391 - (AMOXICILLIN : 875 MG) (CLAVULANIC ACID : 125 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 : 16-Jan-2024

Signature :

Date : 16-Jan-2024