

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : SAMIR ELSAYED MOHAMED
Card No : I017-029-117981249-02
Policy Holder : SAMIR ELSAYED MOHAMED
Payer Name : ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC
TPA : E CARE - Green Network
Validity : 01-01-1900 To 30-09-2024
Gender : Male
Date Of Birth : 17-Sep-1988
Patient's Tel No : 0528156822

Service Date : 16-Jan-2024
Health Provider : Irham Medical Center Arjan
Doctor's Name : Sajid Sanaullah
Co-Insurance :

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

Network : Green
Direct Access SP - YES

Remarks :

☐ Acute
 ☐ Pre-existing and chronic
 ☐ Maternity

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

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
Estimated :
Cost
 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

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

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 :

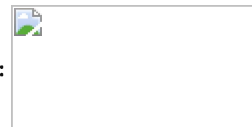
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Sajid Sanaullah

Stamp :



Patient 's signature{Parent : if minor}



Date : 16-Jan-2024

Signature :

Date : 16-Jan-2024