Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: SUJAL PARBAT**	**Service Date**	**:20-Jan-2024**	**Network**	**:** Green
Card No	**: I017-029-120038783-01**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	**: SUJAL PARBAT**	**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	**: 31-Jul-2002**				
Patient's Tel No	**: 554857889**				

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 : co itching all over the body espacially in feet oe redness is present on the feet scratching on the feet small t scraches on all over the boby chest is clear otherwise normal **Duration:**

Vitals: Temp : 36.8 Bp :115 Pulse :82 Resp :18

Clinical Findings:

Diagnosis: L29.9 - Pruritus, unspecified,B35.3 - Tinea pedis,L53.9 - Erythematous condition, unspecified, **Date of Onset :**20/21/2024

Requested Investigations: 0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,0005-111805-1021, CHLOROHISTOL 10MG-(CHLORPHENIRAMINE MALEATE : 10 MG/ML) SOLUTION FOR INJECTION,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,85652, SEDIMENTATION RATE RBC AUTOMATED,9, Consultation GP,96360, HYDRATION IV INFUSION INIT,96365, THER/PROPH/DIAG IV INF INIT,96374, THER/PROPH/DIAG INJ IV PUSH **Estimated Cost :**

Prescriptions: 0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,0005-119805-1171 - (PREDNISOLONE : 5 MG) TABLETS,0207-140504-0151 - (CLOTRIMAZOLE : 1%) CREAM, **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 : 20-Jan-2024

Signature :

Date : 20-Jan-2024