Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **MUHAMMAD ISLAM KHAN DAD**	**Service Date**	**:21-Jan-2024**	**Network**	: Green
Card No	: **I017-029-119843963-01**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	: **MUHAMMAD ISLAM KHAN DAD**	**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	: **14-Mar-1995**				
Patient's Tel No	: **0556629295**				

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 SEVERE PRURITIS ALL OVER BODY ESPECIALLY ON BACK SINCE 3 WEEKS **Duration:**
O/E RASHES AND SOME SCALES ON BODY

Vitals: Temp : 36.8 Bp :119 Pulse :80 Resp :22

Clinical Findings:

Diagnosis: L29.9 - Pruritus, unspecified,B86 - Scabies,L20.9 - Atopic dermatitis, unspecified, **Date of Onset** :21/34/2024

Estimated Cost :

Requested Investigations: 9.01, Follow Up Consultation GP

Prescriptions: 6955-348407-0571 - (PERMETHRIN : 5% W/V) LOTION,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,0005-119805-1172 - (PREDNISOLONE : 5 MG) 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 : 21-Jan-2024

Signature :

Date : 21-Jan-2024