Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **SAMIR ELSAYED MOHAMED ALI GOMAA**	**Service Date**	**:23-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**	**:Enomen Goodluck**		
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: Multiple small rashes globally distributed, including on the fingers and webspaces, trunk and perineum, They are highly pruritic. Exam: Maculopapular rashes, has red bases. Ass: Scabies. **Duration:**

Vitals: Temp : 36.7 Bp :118 Pulse :92 Resp :20

Clinical Findings:

Diagnosis: B86 - Scabies,L29.8 - Other pruritus,L20.9 - Atopic dermatitis, unspecified, **Date of Onset** :23/01/2024

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

Prescriptions: 0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,1157-348401-0151 - (PERMETHRIN : 5%) 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.

Dr's Name : Enomen Goodluck **Stamp :**

Dr. Enomen Goodluck Ekata
General Practitioner
DHA No: 28040827-001
PESHAWAR MEDICAL CENTER LLC
DUBAI : U.A.E.

Signature : **Date** : 23-Jan-2024

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.

Patient 's signature{Parent : if minor} **Date :** 23-Jan-2024