

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : SAMIR ELSAYED MOHAMED
ALI GOMAA
Card No : I017-029-117981249-02
Policy Holder : SAMIR ELSAYED MOHAMED
ALI GOMAA
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 : 23-Jan-2024
Health Provider : Irham Medical Center Arjan
Doctor's Name : Enomen Goodluck
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: 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.

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 :

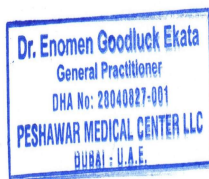
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

PATIENT'S DECLARATION :

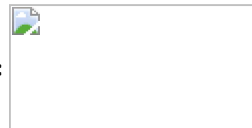
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Enomen Goodluck

Stamp :



Patient's signature{Parent : if minor}



Date : 23-Jan-2024

Signature :

Date : 23-Jan-2024