

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name

: MAHESH ALE MAGAR

Card No

: I017-029-117164888-02

Policy Holder

: MAHESH ALE MAGAR

Payer Name

: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC

TPA

: E CARE - Green Network

Validity

: 01-10-2023 To 30-09-2024

Gender

: Male

Date Of Birth

: 09-Aug-1996

Patient's Tel No

: 524981504

Service Date

:05-Feb-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 REDNESS , BURNING AND WATERY DISCHARGE FROM BOTH EYES SINCE 1 DAY ON ASSESMENT PT HAS HYPREMIC SWOLLEN EYES AND WATERY DISCHARHE BUT VISION IS NORMAL OTHERWISE

Vitals:Temp

: 36.9 Bp :109 Pulse :86 Resp :18

Clinical Findings:

Diagnosis:

H10.9 - Unspecified conjunctivitis,H10.45 - Other chronic allergic conjunctivitis,R51.9 - Headache, unspecified,H57.10 - Ocular pain, unspecified eye,

Date of Onset

:05/00/2024

Requested Investigations:

9, Consultation GP

Estimated Cost

:

Prescriptions:

0085-243301-0371 - (OLOPATADINE : 2 MG/ML) EYE DROPS,0085-239201-0371 - (DEXAMETHASONE : 0.10%) (TOBRAMYCIN : 0.3%) EYE DROPS,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,0005-252201-0391 - (CAFFEINE : 65 MG) (IBUPROFEN : 400 MG) FILM COATED 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

:

Dr. Sajid Sanaullah Khan

General Practitioner

DHA No: 05758224-001

PESHAWAR MEDICAL CENTER LLC

DUBAI - U.A.E.

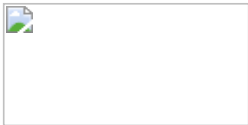
Signature

:

Date

: 05-Feb-2024

Patient 's signature{Parent : if minor}

:

Date

: Feb-2024