Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: CHAN THAR WIN**	**Service Date**	**:11-Feb-2024**	**Network**	**:** Green
Card No	**: I017-029-118780637-01**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	**: CHAN THAR WIN**	**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	**: 23-Nov-2002**				
Patient's Tel No	**: 0589232011**				

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: requesting a medical report for his history of allergy. Has had multiple visits of recurrent allergies for which he was managed in this facility. **Duration:**

Vitals: Temp : 36.5 Bp :121 Pulse :75 Resp :22

Clinical Findings:

Diagnosis: L50.0 - Allergic urticaria, **Date of Onset** : 11/07/2024

Requested Investigations: 9, Consultation GP **Estimated Cost** :

Prescriptions: **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 : 11-Feb-2024

Signature :

Date : 11-Feb-2024