Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: SOPHIE MARIE MATON**	**Service Date**	**:12-Feb-2024**
Card No	**: I017-029-119842089-01**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	**: SOPHIE MARIE MATON**	**Doctor's Name**	**:Sajid Sanaullah**
Payer Name	**: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:
TPA	**: E CARE - Blue Network**	**Remarks**	:
Validity	**: 14-09-2023** To **13-09-2024**		
Gender	**: Female**		
Date Of Birth	**: 02-Sep-1992**		
Patient's Tel No	**: 0521793318**		

Network : Green

Direct Access SP - YES

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: A case of recurrent tonsillar stones. Counselled on the need for surgery as this has been recurrent for many months now. **Duration:**

Vitals: Temp : 36.8 Bp :110 Pulse :80 Resp :6118

Clinical Findings:

Diagnosis: J35.8 - Other chronic diseases of tonsils and adenoids, **Date of Onset** : 12/54/2024

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 : 12-Feb-2024

Signature :

Date : 12-Feb-2024