Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: ALI RAZA MUHAMMAD**	**Service Date**	**:13-Feb-2024**
Card No	**: I017-029-119380179-01**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	**: ALI RAZA MUHAMMAD**	**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	**: 01-Apr-1993**		
Patient's Tel No	**: 0528143042**		

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 : Represented: Still has severe pains underneath his right foot. SPecifically located at the heal (Posterior 1/3rd). Exam: markedly tender, warm and has pustular appearance within it. I&D is advised.

Duration:

Vitals:

Clinical Findings:

Diagnosis: L02.621 - Furuncle of right foot,

Date of Onset : 13/09/2024

Requested Investigations: 10061, INCISION&DRAINAGE ABSCESS COMPLICATED/MULTIPLE,96372, THER/PROPH/DIAG INJ SC/IM,0005-149902-1021, CLOFEN ,10060, DRAINAGE OF SKIN ABSCESS,9.01, Follow Up Consultation GP

Estimated Cost :

Prescriptions:

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 : 13-Feb-2024

Signature :

Date : 13-Feb-2024