Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: ALI RAZA MUHAMMAD**	**Service Date**	**:15-Feb-2024**	**Network**	**:** Green
Card No	**: I017-029-119380179-01**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
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**				

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 : For follow up and wound dressing. **Duration :**

Vitals: Temp : 36.6 Bp :89 Pulse :76 Resp :0

Clinical Findings:

Diagnosis: L02.621 - Furuncle of right foot, **Date of Onset :** 15/23/2024

Requested Investigations: 9.01, Follow Up Consultation GP,51.02, Non-surgical cleansing with surgical dressing between 16 sq inches / 100 sq centimeters and 48 sq inches / 300 sq centimeters **Estimated Cost :**

Prescriptions: 0248-106304-0271 - (ASCORBIC ACID (VITAMIN C) : 1 G) EFFERVESCENT TABLETS,0027-149903-0391 - (DICLOFENAC SODIUM : 100 MG) FILM COATED TABLETS,0152-116604-0391 - (METRONIDAZOLE : 500 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 :**

Patient 's signature{Parent : if minor}

Date : 15-Feb-2024

Signature :

Date : 15-Feb-2024