Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: MA AURENA ALCANTARA	**Service Date**	:17-Feb-2024	**Network**	: Green
Card No	: I017-029-120241557-01	**Health Provider**	:Irham Medical Center Arjan		**Direct Access SP - YES**
Policy Holder	: MA AURENA ALCANTARA	**Doctor's Name**	:Sajid Sanaullah		
Payer Name	: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC	**Co-Insurance**	:		
TPA	: E CARE - Green Network	**Remarks**	:		
Validity	: 21-12-2023 To 30-09-2024				
Gender	: Male				
Date Of Birth	: 23-Oct-1977				
Patient's Tel No	: 0559544278				

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: Diarrhea since yesterday evening, had 5 episodes this morning alone. There is associated upper abdominal pain that is burning in nature. There is no fever and no vomiting and no urinary symptoms and has no significant past medical nor surgical history. Also complained of itchy lesions on the lower limb and back. Lesions look tinea. **Duration:**

Vitals: Temp : 36.6 Bp :101 Pulse :99 Resp :22

Clinical Findings:

Diagnosis: K29.00 - Acute gastritis without bleeding,R19.7 - Diarrhea, unspecified,B49 - Unspecified mycosis,L29.8 - Other pruritus, **Date of Onset** :17/52/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,0207-214402-0151 - (BETAMETHASONE : N/A) (CLOTRIMAZOLE : N/A) CREAM,0042-136501-1173 - (HYOSCINE : 10 MG) TABLETS,0005-141607-1111 - (ALUMINIUM HYDROXIDE : 215 MG/5 ML) (SIMETHICONE : 25 MG/5ML) (MAGNESIUM HYDROXIDE : 80 MG/5ML) SUSPENSION,0188-232401-0392 - (ESOMEPRAZOLE : 40 MG) FILM COATED TABLETS,0027-109204-1171 - (TERBINAFINE (AS HCL) : 250 MG) 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 : 17-Feb-2024

Signature :

Date : 17-Feb-2024