Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: RUBIN MAHARJAN**	**Service Date**	**:19-Feb-2024**	**Network**	**:** Green
Card No	**: I017-029-117174621-02**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	**: RUBIN MAHARJAN**	**Doctor's Name**	**:Sajid Sanaullah**		
Payer Name	**: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:		
TPA	**: E CARE - Blue Network**	**Remarks**	:		
Validity	**: 01-10-2023** To **30-09-2024**				
Gender	**: Male**				
Date Of Birth	**: 26-Jun-1998**				
Patient's Tel No	**: 0588812699**				

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 OITCHING AND DISCHARGE FROM EYES SINCE 6 DAYS ON EXAMINATION **Duration:**
PT HAS DRYNESS AND REDNESS IN BOTH EYES

Vitals: Temp : 36.7 Bp :125 Pulse :78 Resp :22

Clinical Findings:

Diagnosis: H10.33 - Unspecified acute conjunctivitis, bilateral,T78.40XA - Allergy, unspecified, initial encounter, **Date of Onset :**19/20/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0085-239201-0371 - (DEXAMETHASONE : 0.10%) (TOBRAMYCIN : 0.3%) EYE DROPS,0085-243302-0371 - (OLOPATADINE : 0.1%) EYE DROPS,

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 : 19-Feb-2024

Signature :

Date : 19-Feb-2024