

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : IULIA KONINA
Card No : I017-029-119862292-01
Policy Holder : IULIA KONINA
Payer Name : ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC
TPA : E CARE - Green Network
Validity : 01-10-2023 To 30-09-2024
Gender : Female
Date Of Birth : 28-Oct-2000
Patient's Tel No : 585054133

Service Date : 19-Feb-2024 Network : Green
Health Provider : Irham Medical Center Arjan Direct Access SP - YES
Doctor's Name : Sajid Sanaullah

Co-Insurance	CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
	10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

Remarks :

☐ Acute ☐ Pre-existing and chronic ☐ Maternity

Chief Complaints : C/o: Redness and severe itching of the skin of the chest, taking the shape of a bra. Onset is exactly one week ago. There is no fever. Ass: Allergic contact dermatitis ?? cause

Vitals:Temp : 36.6 Bp :109 Pulse :76 Resp :22

Clinical Findings:

Diagnosis: L23.9 - Allergic contact dermatitis, unspecified cause,B49 - Unspecified mycosis,L29.9 - Pruritus, unspecified, **Date of Onset** :19/27/2024

Estimated Cost :**Requested Investigations:** 9, Consultation GP

Prescriptions: 0005-119805-1172 - (PREDNISOLONE : 5 MG) TABLETS,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,0207-214402-0151 - (BETAMETHASONE : N/A) (CLOTRIMAZOLE : N/A) CREAM,

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