Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **RAKESH KIZHAKKE VEETTIL KELAMBATH RAJAN**	**Service Date**	**:20-Feb-2024**	**Network**	: Green
Card No	: **I017-029-116524278-02**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	: **RAKESH KIZHAKKE VEETTIL KELAMBATH RAJAN**	**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-Jan-1980**				
Patient's Tel No	: **971502044580**				

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: Dark linear discolouration on the forehead. Said to have been working with chemicals for cleaning drains when it splashed and a drop went unto his head resulting in the injujry. Exam: Line of contact is seen as dark hyperpigmentation on the forehead. Chemical burns suspected, allergic contact dermatitis. **Duration:**

Vitals: Temp : 0 Bp :150 Pulse :68 Resp :22

Clinical Findings:

Diagnosis: T20.40XA - Corros unsp degree of head, face, and neck, unsp site, init,L23.2 - Allergic contact dermatitis due to cosmetics, **Date of Onset** :20/21/2024

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

Prescriptions: 1111-183202-0391 - (FEXOFENADINE HCL : 180 MG) FILM COATED TABLETS,0184-122501-0152 - (PANTHENOL : 5%) (SILVER SULFADIAZINE : 1%) 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 : 20-Feb-2024

Signature :

Date : 20-Feb-2024