Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: PRASANTH SELVARAJAH**	**Service Date**	**:23-Feb-2024**
Card No	**: I017-029-117672857-02**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	**: PRASANTH SELVARAJAH**	**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	**: 10-Jun-1997**		
Patient's Tel No	**: 971503593847**		

Network : Green

Direct Access SP - YES

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 : severe skin rash since three days started from small papules now scaling and itching started 20/2/2024 **Duration:**

Vitals: Temp : 36.7 Bp :111 Pulse :62 Resp :22

Clinical Findings:

Diagnosis: T78.40XA - Allergy, unspecified, initial encounter, **Date of Onset** : 23/51/2024

Requested Investigations: 0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,0005-111805-1021, CHLOROHISTOL 10MG,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP **Estimated Cost** :

Prescriptions: 7048-140201-0061 - (FLUCONAZOLE : 150 MG) CAPSULES,0205-123701-0391 - (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 : 23-Feb-2024

Signature :

Date : 23-Feb-2024