

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : Shivani Ravi Naik

Card No : I017-029-120499230-01

Policy Holder : Shivani Ravi Naik

Payer Name : ABU DHABI NATIONAL
INSURANCE COMPANY-ADNIC

TPA : E CARE - Blue Network

Validity : 22-02-2024 To 05-01-2025

Gender : Female

Date Of Birth : 30-Aug-1996

Patient's Tel No : 0556325933

Service Date : 03-Mar-2024

Health Provider : Irham Medical Center Arjan

Doctor's Name : Maimoona

Co-Insurance :

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

Network : Green

Direct Access SP - YES

Remarks :

☐ Acute

☐ Pre-existing and chronic

☐ Maternity

Chief Complaints : history of delayed menstruation her LMP 26/01/2024 history of pcos plan of Duration: care to rule out pregnancy

Vitals: Temp : 36.7 Bp :113 Pulse :72 Resp :22

Clinical Findings:

Diagnosis: N91.2 - Amenorrhea, unspecified,

Date of Onset : 03/08/2024

Requested Investigations: 84702, Beta,Hcg,84702, B HCG (GONADOTROPIN CHORIONIC QUANTITATIVE),9, Consultation GP

Estimated Cost :

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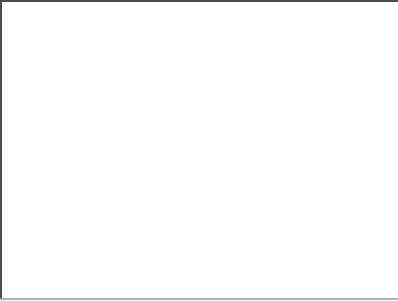
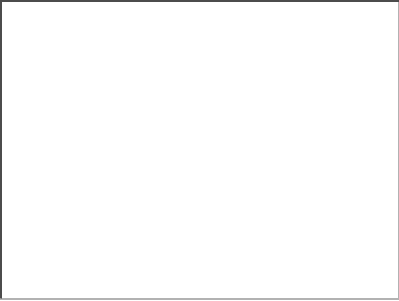
Prescriptions:

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 : Maimoona	Stamp : 	Patient 's signature{Parent : if minor} 	Date : 03-Mar-2024
Signature : 	Date : 03-Mar-2024		