Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: Shivani Ravi Naik**	**Service Date**	**:03-Mar-2024**	**Network**	**:** Green
Card No	**: I017-029-120499230-01**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	**: Shivani Ravi Naik**	**Doctor's Name**	**:Maimoona**		
Payer Name	**: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	**:**		
TPA	**: E CARE - Blue Network**				
Validity	**: 22-02-2024** To **05-01-2025**				
Gender	**: Female**	**Remarks**	**:**		
Date Of Birth	**: 30-Aug-1996**				
Patient's Tel No	**: 0556325933**				

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

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** :

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