Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: IULIIA KONINA	**Service Date**	:13-Mar-2024	**Network**	: Green
Card No	: I017-029-119862292-01	**Health Provider**	:Irham Medical Center Arjan		**Direct Access SP - YES**
Policy Holder	: IULIIA KONINA	**Doctor's Name**	:Enomen Goodluck		
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	: Female				
Date Of Birth	: 28-Oct-2000				
Patient's Tel No	: 585054133				

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: Running nose, and recurrent sneezing. No fever and no pain in throat. **Duration :**

Vitals: Temp : 36.7 Bp :112 Pulse :82 Resp :22

Clinical Findings:

Diagnosis: J30.9 - Allergic rhinitis, unspecified,J01.40 - Acute pansinusitis, unspecified, **Date of Onset** :13/30/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0097-127405-0391 - (AZITHROMYCIN : 500 MG) FILM COATED TABLETS,0993-649501-3591 - (MOMETASONE FUROATE (AS MONOHYDRATE) : 50 MCG/DOSE) SUSPENSION FOR NASAL SPRAY,1111-183202-0391 - (FEXOFENADINE HCL : 180 MG) FILM COATED TABLETS, **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.

Dr's Name : Enomen Goodluck

Stamp :

Dr. Enomen Goodluck Ekata
General Practitioner
DHA No: 28040827-001
PESHAWAR MEDICAL CENTER LLC
DUBAI : U.A.E.

Signature :

Date : 13-Mar-2024

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.

Patient 's signature{Parent : if minor}

Date : 13-Mar-2024