

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : SUKESH AREEKARA
NARAYANAN KALLIYADAN
Card No : I017-029-119448896-01
Policy Holder : SUKESH AREEKARA
NARAYANAN KALLIYADAN
Payer Name : ABU DHABI NATIONAL
INSURANCE COMPANY-ADNIC
TPA : E CARE - Green Network
Validity : 01-10-2023 To 30-09-2024
Gender : Male
Date Of Birth : 25-Apr-1985
Patient's Tel No : 0586787640

Service Date : 16-Mar-2024
Health Provider : Irham Medical Center Arjan
Doctor's Name : Enomen Goodluck
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 : Right sided lower abdominal pain for the past 1 week. Low back pain since 2 Duration: days, There is no fever, no nausea, no vomiting, and no change in bowel movement.

Vitals: Temp : 36.8 Bp :110 Pulse :82 Resp :22

Clinical Findings:

Diagnosis: K36 - Other appendicitis, M54.5 - Low back pain, Date of Onset : 16/01/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0005-107906-0431 - (IBUPROFEN : 5%) GEL, 0042-136501-1173 - (HYOSCINE : 10 MG) Estimated : TABLETS, 0135-223401-1171 - (NAPROXEN : 500 MG) TABLETS, 0152-116604-0391 - (METRONIDAZOLE Cost : 500 MG) FILM COATED TABLETS, 0097-103201-0392 - (CIPROFLOXACIN : 500 MG) FILM COATED TABLETS,

MEDICAL PRACTITIONER DECLARATION :

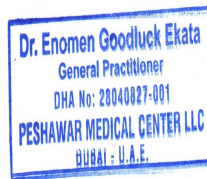
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

PATIENT'S DECLARATION :

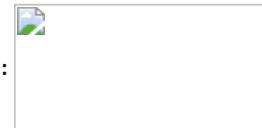
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Enomen Goodluck

Stamp :



Patient's signature {Parent : if minor}



16-
Date : Mar-2024

Signature :

Date : 16-Mar-2024