Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **SUKESH AREEKARA NARAYANAN KALLIYADAN**	**Service Date**	**:16-Mar-2024**	**Network**	**:** Green
Card No	: **I017-029-119448896-01**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	: **SUKESH AREEKARA NARAYANAN KALLIYADAN**	**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	: **Male**				
Date Of Birth	: **25-Apr-1985**				
Patient's Tel No	: **0586787640**				

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 : Right sided lower abdominal pain for the past 1 week. Low back pain since 2 days, There is no fever, no nausea, no vomiting, and no change in bowel movement. **Duration:**

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

Requested Investigations: 9, Consultation GP **Estimated Cost** :

Prescriptions: 0005-107906-0431 - (IBUPROFEN : 5%) GEL,0042-136501-1173 - (HYOSCINE : 10 MG) TABLETS,0135-223401-1171 - (NAPROXEN : 500 MG) TABLETS,0152-116604-0391 - (METRONIDAZOLE : 500 MG) FILM COATED TABLETS,0097-103201-0392 - (CIPROFLOXACIN : 500 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** : 16-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 :** 16-Mar-2024