

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : RAVINDRA SINGH KUWAR SINGH
Card No : I017-029-119843965-01
Policy Holder : RAVINDRA SINGH KUWAR SINGH
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 : 16-Jun-1987
Patient's Tel No : 0521136987

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 : C/o: Pruritic skin lesions on the groin. Patient has declined examination. **Duration:** However described the lesion as circumferential with active margin, which has now got wider over time.

Vitals: Temp : 36.5 Bp :117 Pulse :76 Resp :18

Clinical Findings:

Diagnosis: J02.9 - Acute pharyngitis, unspecified, J21.9 - Acute bronchiolitis, unspecified, **Date of Onset** : 16/20/2024

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

Prescriptions: 0207-214402-0151 - (BETAMETHASONE : N/A) (CLOTRIMAZOLE : N/A) CREAM, 0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS, 0027-109204-1171 - (TERBINAFINE (AS HCL) : 250 MG) TABLETS, **Estimated Cost** :

MEDICAL PRACTITIONER DECLARATION :

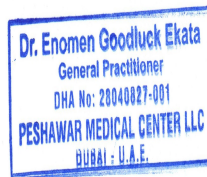
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

PATIENT'S DECLARATION :

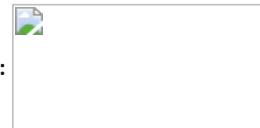
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Enomen Goodluck

Stamp :



Patient's signature {Parent : if minor}



Date : 16-Mar-2024

Signature :

Date : 16-Mar-2024