Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: YASSINE MEZOLY**	**Service Date**	**:16-Mar-2024**	**Network**	**:** Green
Card No	**: I017-029-118908548-01**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	**: YASSINE MEZOLY**	**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	**: 20-Oct-1992**				
Patient's Tel No	**: 0562436327**				

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: Anal pain since last night (18hours) ago. There was associated protrusion of surrounding anal skin but no bleeding per rectum. Stool was hard. Has a similar history in the past and has been managed for hemorrhoid on multiple occasions, beginning from 3 years ago. DRE declined. **Duration:**

Vitals: Temp : 36.7 Bp :128 Pulse :74 Resp :22

Clinical Findings:

Diagnosis: K60.0 - Acute anal fissure,K64.8 - Other hemorrhoids, **Date of Onset** **:** 16/59/2024

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

Prescriptions: 0027-142201-0831 - (DICLOFENAC POTASSIUM : 50 MG) POWDER FOR SOLUTION,0071-158501-0391 - (HESPERIDIN : 50 MG) (DIOSMIN (FLAVONOIDIC FRACTION) : 450 MG) FILM COATED TABLETS,0027-149903-2231 - (DICLOFENAC SODIUM : 100 MG) RECTAL SUPPOSITORIES,1291-170801-1161 - (LACTULOSE : 66.7%) SYRUP, **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