

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : LEAH MARCELO APOSTOL Service Date :19-Mar-2024 Network : Green
Card No : I017-029-116125800-02 Health Provider :Irham Medical Center Arjan Direct Access SP - YES
Policy Holder : LEAH MARCELO APOSTOL Doctor's Name :Enomen Goodluck
Payer Name : ABU DHABI NATIONAL Co-Insurance :

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

TPA : E CARE - Green Network Remarks :
Validity : 01-10-2023 To 30-09-2024
Gender : Female
Date Of Birth : 06-May-1978
Patient's Tel No : 0525696874

☐ Acute ☐ Pre-existing and chronic ☐ Maternity

Chief Complaints : For medication refill. Duration :

Vitals:Temp : 36.7 Bp :130 Pulse :82 Resp :18

Clinical Findings:

Diagnosis: I10 - Essential (primary) hypertension,Z79.899 - Other long term (current) drug therapy,M79.2 - Date of Onset :19/33/2024
Neuralgia and neuritis, unspecified,

Requested Investigations: 9, Consultation GP Estimated Cost :

Prescriptions: 0252-155401-0391 - (LOSARTAN POTASSIUM : 50 MG) FILM COATED TABLETS, Estimated Cost :

MEDICAL PRACTITIONER DECLARATION :

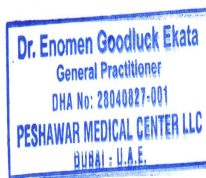
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

PATIENT'S DECLARATION :

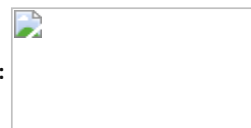
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Enomen Goodluck

Stamp :



Patient's signature{Parent : if minor}



19-
Date : Mar-
2024

Signature :

Date : 19-Mar-2024