Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: LEAH MARCELO APOSTOL**	**Service Date**	**:19-Mar-2024**
Card No	**: I017-029-116125800-02**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	**: LEAH MARCELO APOSTOL**	**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	**: Female**		
Date Of Birth	**: 06-May-1978**		
Patient's Tel No	**: 0525696874**		

Network : Green

Direct Access SP - YES

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 : 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 - Neuralgia and neuritis, unspecified, **Date of Onset** :19/33/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Estimated Cost :

Prescriptions: 0252-155401-0391 - (LOSARTAN POTASSIUM : 50 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.

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 : 19-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 : 19-Mar-2024