Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: JOHN BARRY OMONDI**	**Service Date**	**:25-Mar-2024**	**Network**	**:** Green
Card No	**: I017-029-119050814-01**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	**: JOHN BARRY OMONDI**	**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	**: 04-Nov-1999**				
Patient's Tel No	**: 0555219621**				

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 : High grade fever, diarrhea since yesterday. Temperature at presentation = 39.4 **Duration:**

Vitals: Temp : 39.4 Bp :120 Pulse :102 Resp :93

Clinical Findings:

Diagnosis: A09 - Infectious gastroenteritis and colitis, unspecified,R50.9 - Fever, unspecified, **Date of Onset** :25/25/2024

Requested Investigations: 96372, THER/PROPH/DIAG INJ SC/IM,0005-149902-1021, CLOFEN ,9, Consultation GP **Estimated Cost** :

Prescriptions: 0042-136501-1173 - (HYOSCINE : 10 MG) TABLETS,0188-232401-0391 - (ESOMEPRAZOLE : 40 MG) FILM COATED TABLETS,0005-106601-1171 - (PARACETAMOL : 500 MG) TABLETS,0097-103201-0391 - (CIPROFLOXACIN : 500 MG) FILM COATED TABLETS,0027-149903-2231 - (DICLOFENAC SODIUM : 100 MG) RECTAL SUPPOSITORIES, **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 :**

Dr. Enomen Goodluck Ekata
General Practitioner
DHA No: 20040827-001
PESHAWAR MEDICAL CENTER LLC
DUBAI : U.A.E.

Patient 's signature{Parent : if minor} **Date :** 25-Mar-2024

Signature : **Date** : 25-Mar-2024