

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : CHHIDEN LEPCHA LADEN
Card No : I017-029-118001589-02
Policy Holder : CHHIDEN LEPCHA LADEN
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 : 12-Oct-1997
Patient's Tel No : 0561466470

Service Date : 30-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 : Urethral discharge, pain on passing urine and fever. symptoms since 2 days. Duration: Has significant patronage with commercial sex workers.

Vitals:Temp : 36.7 Bp :109 Pulse :88 Resp :18

Clinical Findings:

Diagnosis: N34.1 - Nonspecific urethritis,R36.0 - Urethral discharge without blood,R30.9 - Painful micturition, Date of Onset :30/09/2024
unspecified,R50.9 - Fever, unspecified,

Requested Investigations: 96372, THER/PROPH/DIAG INJ SC/IM,0195-107704-0802, CEFTRIAXONE- Estimated :
TABUK IM,87075, CULTURE BACTERIAL ANY SOURCE ANAEROBIC ISO&ID,85025, BLOOD COUNT Cost
COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,81001, URNLS DIP
STICK/TABLET REAGENT AUTO MICROSCOPY,9, Consultation GP

Prescriptions: 1516-107902-1171 - (IBUPROFEN : 400 MG) TABLETS,0097-127405-0391 - Estimated :
(AZITHROMYCIN : 500 MG) FILM COATED TABLETS,0152-116604-0391 - (METRONIDAZOLE : 500 MG) Cost
FILM COATED TABLETS,0005-169101-1451 - (DOXYCYCLINE : 100 MG) CAPSULES (HARD GELATIN),

MEDICAL PRACTITIONER DECLARATION :

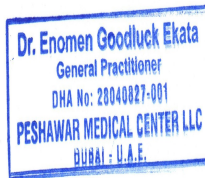
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

PATIENT'S DECLARATION :

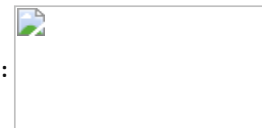
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Enomen Goodluck

Stamp :



Patient's signature{Parent : if minor}



30-
Date : Mar-2024

Signature :

Date : 30-Mar-2024