Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **CHHIDEN LEPCHA LADEN LEPCHA**	**Service Date**	**:30-Mar-2024**	**Network**	: Green
Card No	: **I017-029-118001589-02**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	: **CHHIDEN LEPCHA LADEN LEPCHA**	**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	: **12-Oct-1997**				
Patient's Tel No	: **0561466470**				

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 : 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, unspecified,R50.9 - Fever, unspecified, **Date of Onset** :30/30/2024

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

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

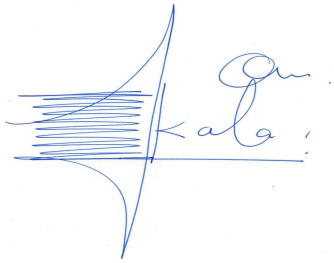
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Enomen Goodluck **Stamp :**

Patient 's signature{Parent if minor} :

Date : 30-Mar-2024

Signature :



Date : 30-Mar-2024