Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: CHAN THAR WIN**	**Service Date**	**:02-Apr-2024**
Card No	**: I017-029-118780637-01**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	**: CHAN THAR WIN**	**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	**: 23-Nov-2002**		
Patient's Tel No	**: 0589232011**		

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 : rashes on the posterior neck. Said to have been noticed 2 days after the commencement of a new type of aloe vera body lotion. There is associated pruritus. **Duration:**

Vitals: Temp : 36.6 Bp :122 Pulse :78 Resp :18

Clinical Findings:

Diagnosis: L20.9 - Atopic dermatitis, unspecified,L50.0 - Allergic urticaria, **Date of Onset** :02/54/2024

Requested Investigations: 9, Consultation GP **Estimated Cost** :

Prescriptions: 1069-108101-0391 - (DESLORATADINE : 5 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.

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 : 02-Apr-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 : 02-Apr-2024