Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: LEAH MARCELO APOSTOL**	**Service Date**	**:02-Apr-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 : Headache for the past 4 days. **Duration :**

Vitals: Temp : 37.2 Bp :127 Pulse :76 Resp :18

Clinical Findings:

Diagnosis: R51.9 - Headache, unspecified,R05 - Cough, **Date of Onset** : 02/01/2024

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,9, Consultation GP **Estimated Cost :**

Prescriptions: 0006-106601-0391 - (PARACETAMOL : 500 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