

## Administrative

## MEDICAL CLAIM FORM

## Claim Ref:

Patient Name : LEAH MARCELO APOSTOL Service Date :02-Apr-2024 Network : Green  
Card No : I017-029-116125800-02 Health Provider :Irham Medical Center Arjan Direct Access SP - YES  
Policy Holder : LEAH MARCELO APOSTOL Doctor's Name :Enomen Goodluck  
Payer Name : ABU DHABI NATIONAL Co-Insurance :

|              |               |        |           |     |           |        |
|--------------|---------------|--------|-----------|-----|-----------|--------|
| CONSULTATION | LAB/RADIOLOGY | PHYSIO | PHARMACY  | IP  | MATERNITY | DENTAL |
| 10% max      | NIL           | NIL    | NIL LIMIT | NIL | 10%       | NA     |

  
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

☐ 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 :

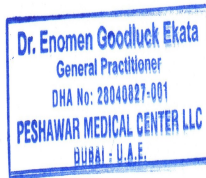
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

## PATIENT'S DECLARATION :

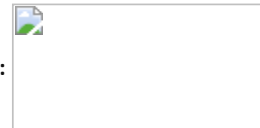
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Enomen Goodluck

Stamp :



Patient's signature{Parent : if minor}



02-Apr-2024

Signature :

Date : 02-Apr-2024