Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: Tami Pricylia Kalebu**	**Service Date**	**:06-Apr-2024**	**Network**	**: Green**
Card No	**: I017-029-118527263-01**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	**: Tami Pricylia Kalebu**	**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	**: 11-May-1991**				
Patient's Tel No	**: 0567956019**				

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 : C/o: oral sores with pain and blistering. Not a known diabetic and HIV is negative as per last visa application 2months ago. **Duration:**

Vitals: Temp : 36.4 Bp :107 Pulse :70 Resp :18

Clinical Findings:

Diagnosis: K14.0 - Glossitis,R52 - Pain, unspecified,E56.9 - Vitamin deficiency, unspecified, **Date of Onset** :06/56/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0027-142201-0832 - (DICLOFENAC POTASSIUM : 50 MG) POWDER FOR SOLUTION,5254-830602-2401 - (VITAMIN B1 (THIAMINE) : 100 MG) (VITAMIN B6 (AS PYRIDOXINE HCL) : 200 MG) (VITAMIN B12 (CYANOCOBALAMIN) : 200 MCG) SUGAR COATED TABLETS,0349-106203-1171 - (MULTIVITAMINS : 30 MG) (MINERALS : 30 MG) 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 : 06-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 : 06-Apr-2024