

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : Tami Pricylia Kalebu

Card No : I017-029-118527263-01

Policy Holder : Tami Pricylia Kalebu

Payer Name : ABU DHABI NATIONAL
INSURANCE COMPANY-
ADNIC

TPA : E CARE - Green Network

Validity : 01-10-2023 To 30-09-2024

Gender : Female

Date Of Birth : 11-May-1991

Patient's Tel No : 0567956019

Service Date : 06-Apr-2024

Health Provider : Irham Medical Center Arjan

Doctor's Name : Enomen Goodluck

Network : Green

Direct Access SP - YES

Co-Insurance :

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

Remarks :

☐ 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- Estimated :
830602-2401 - (VITAMIN B1 (THIAMINE) : 100 MG) (VITAMIN B6 (AS PYRIDOXINE HCL) : 200 MG) Cost
(VITAMIN B12 (CYANOCOBALAMIN) : 200 MCG) SUGAR COATED TABLETS,0349-106203-1171 -
(MULTIVITAMINS : 30 MG) (MINERALS : 30 MG) TABLETS,

MEDICAL PRACTITIONER DECLARATION :

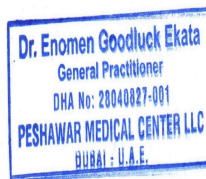
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

PATIENT'S DECLARATION :

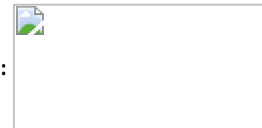
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Enomen Goodluck

Stamp :



Patient's signature{Parent : if minor}

06-
Date : Apr-
2024

Signature :

Date : 06-Apr-2024