Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **MOHIT KUMAR NARESH CHANDRA**	**Service Date**	**:07-Apr-2024**	**Network**	: Green
Card No	: **I017-029-117742793-02**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	: **MOHIT KUMAR NARESH CHANDRA**	**Doctor's Name**	**:Sajid Sanaullah**		
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	: **25-Jun-1995**				
Patient's Tel No	: **0564670216**				

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 : **Duration :**

Vitals: Temp : 36.5 Bp :120 Pulse :78 Resp :18

Clinical Findings:

Diagnosis: H92.02 - Otalgia, left ear,H61.20 - Impacted cerumen, unspecified ear, **Date of Onset** :07/30/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Estimated Cost :

Prescriptions: 0195-142201-0111 - (DICLOFENAC POTASSIUM : 50 MG) COATED 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 : Sajid Sanaullah

Stamp :

Patient 's signature{Parent if minor} :

Date : 07-Apr-2024

Signature :

Date : 07-Apr-2024