Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **BIJAYA ADHIKARI SHANKHAR ADHIKARI**	**Service Date**	**:08-Apr-2024**
Card No	: **I017-029-116896784-02**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	: **BIJAYA ADHIKARI SHANKHAR ADHIKARI**	**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	: **26-Oct-1981**		
Patient's Tel No	: **0555820611**		

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 : multiple pruritic lesions widely distributed all over the body; more concentrated on the feet and hands. Atopic dermatitis suspected Scabies.

Duration:

Vitals: Temp : 36.7 Bp :98 Pulse :81 Resp :18

Clinical Findings:

Diagnosis: L20.9 - Atopic dermatitis, unspecified,B86 - Scabies,L29.8 - Other pruritus,

Date of Onset :08/04/2024

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

Estimated Cost :

Prescriptions: 1157-348401-0151 - (PERMETHRIN : 5%) CREAM,0005-119803-1171 - (PREDNISOLONE : 20 MG) TABLETS,1111-183202-0391 - (FEXOFENADINE HCL : 180 MG) FILM COATED TABLETS,

Estimated Cost :

MEDICAL PRACTITIONER DECLARATION :

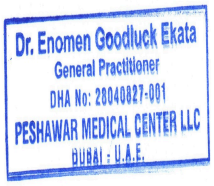
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

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

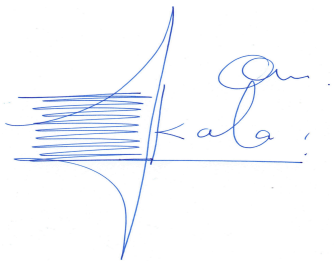
Stamp :



Patient 's signature{Parent if minor} :

Date : 08-Apr-2024

Signature :



Date : 08-Apr-2024