Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **SAYANTAN BARIK MADAN BARIK**	**Service Date**	**:14-Apr-2024**	**Network**	: Green
Card No	: **I017-029-117490451-02**	**Health Provider**	**:Irham Medical Center Arjan**	**Direct Access SP - YES**	
Policy Holder	: **SAYANTAN BARIK MADAN BARIK**	**Doctor's Name**	**:SANDIA**		
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	: **04-Nov-1996**				
Patient's Tel No	: **0502648924**				

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 : pt comes with red right eye. side of the eye is itchyno pain in eye it started 12th night and becam red and worse yesterday. **Duration:**

Vitals: Temp : 37 Bp :118 Pulse :88 Resp :0

Clinical Findings:

Diagnosis: H10.11 - Acute atopic conjunctivitis, right eye, **Date of Onset** : 14/37/2024

Requested Investigations: 9, Consultation GP **Estimated Cost** :

Prescriptions: 1312-383001-0381 - (TOBRAMYCIN SULPHATE : 3 MG/G) EYE OINTMENT,0085-125903-0372 - (MOXIFLOXACIN (AS HCL) : 0.5%) EYE DROPS, **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 : SANDIA **Stamp :**

Dr. Sandia Bhojwani
General Practitioner
DHA No: 65900212-001
PESHAWAR MEDICAL CENTER LLC
DUBAI - U.A.E.

Patient 's signature{Parent if minor} : **Date** : 14-Apr-2024

Signature : **Date** : 14-Apr-2024