Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: JEEVAN JOSEPH	**Service Date**	:24-Apr-2024
Card No	: I017-029-119959938-01	**Health Provider**	:Irham Medical Center Arjan
Policy Holder	: JEEVAN JOSEPH	**Doctor's Name**	:Enomen Goodluck
Payer Name	: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC	**Co-Insurance**	:
TPA	: E CARE - Green Network	**Remarks**	:
Validity	: 01-01-1900 To 30-09-2024		
Gender	: Male		
Date Of Birth	: 09-Mar-2000		
Patient's Tel No	: +919605611892		

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 : oral sore and ulcers. Also low back pain and abdominal discomfort. **Duration :**

Vitals: Temp : 36.5 Bp :128 Pulse :78 Resp :20

Clinical Findings:

Diagnosis: K12.1 - Other forms of stomatitis,E56.9 - Vitamin deficiency, unspecified, **Date of Onset** :24/03/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0270-134501-1431 - (CETALKONIUM CHLORIDE : N/A) (CHOLINE SALICYLATE : 8.7%) BUCCAL GEL,0349-106203-1173 - (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.

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.

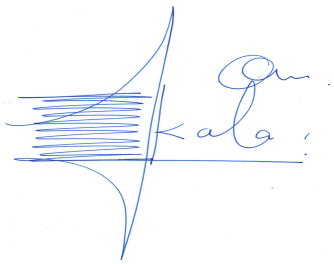
Dr's Name : Enomen Goodluck

Stamp :

Patient 's signature{Parent if minor} :

Date : 24-Apr-2024

Signature :



Date : 24-Apr-2024