Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **NEEVAN NEWTON FERNANDES**	**Service Date**	**:27-Apr-2024**	**Network**	: Green
Card No	: **I017-029-118947916-01**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	: **NEEVAN NEWTON FERNANDES**	**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	: **Male**				
Date Of Birth	: **27-Jun-2001**				
Patient's Tel No	: **554582536**				

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 : Pain on the soles of the right foot since 3 days. Examination: significant hyperemia of the sole of right forefoot. **Duration:**

Vitals: Temp : 36.6 Bp :132 Pulse :92 Resp :20

Clinical Findings:

Diagnosis: L03.115 - Cellulitis of right lower limb,G89.11 - Acute pain due to trauma, **Date of Onset** :27/40/2024

Requested Investigations: 9, Consultation GP,96365, THER/PROPH/DIAG IV INF INIT,0195-107704-0801, CEFTRIAXONE-TABUK IV,0005-149902-1021, CLOFEN ,96372, THER/PROPH/DIAG INJ SC/IM,0046-149902-0511, INFLA-BAN **Estimated Cost** :

Prescriptions: 0005-114501-2481 - (AMBROXOL : 15 MG/5ML) SYRUP (SUGAR FREE),0252-185801-0391 - (DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS,1516-107902-1171 - (IBUPROFEN : 400 MG) TABLETS,0139-116206-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS, **Estimated Cost** :

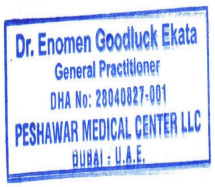
MEDICAL PRACTITIONER DECLARATION :

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.

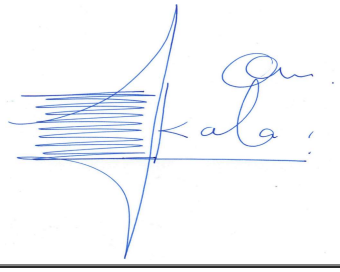
Dr's Name : Enomen Goodluck **Stamp :**



Patient 's signature{Parent if minor} :

Date : 27-Apr-2024

Signature :



Date : 27-Apr-2024