

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : NEEVAN NEWTON FERNANDES
Card No : I017-029-118947916-01
Policy Holder : NEEVAN NEWTON FERNANDES
Payer Name : ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC
TPA : E CARE - Green Network
Validity : 01-10-2023 To 30-09-2024
Gender : Male
Date Of Birth : 27-Jun-2001
Patient's Tel No : 554582536

Service Date : 27-Apr-2024
Health Provider : Irham Medical Center Arjan
Doctor's Name : Enomen Goodluck
Co-Insurance :

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

Network : Green
Direct Access SP - YES

Remarks :

☐ Acute	☐ Pre-existing and chronic	☐ Maternity
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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:

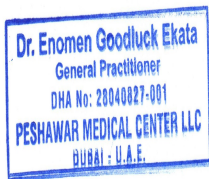
Diagnosis: L03.115 - Cellulitis of right lower limb,G89.11 - Acute pain due to trauma, **Date of Onset** :27/15/2024

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 **Estimated Cost** :

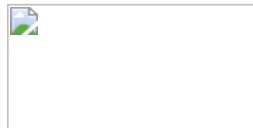
Prescriptions: 0005-114501-2481 - (AMBROXOL : 15 MG/5ML) SYRUP (SUGAR FREE),0252-185801-0391 - (DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS,1516-107902-1171 - (IBUPROFEN : 400 MG) TABLETS,0139-116206-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875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

Signature :  **Date :** 27-Apr-2024

Patient's signature{Parent : if minor}  **Date :** 27-Apr-2024