

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 : 28-Apr-2024
Health Provider : Irham Medical Center Arjan
Doctor's Name : Humaira
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:

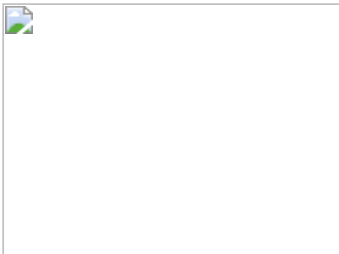
Clinical Findings:

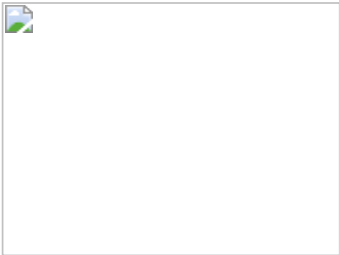
Diagnosis: L03.115 - Cellulitis of right lower limb,G89.11 - Acute pain due to trauma, **Date of Onset** : 28/13/2024

Requested Investigations: 0046-149902-0511, INFLA-BAN ,96372, THER/PROPH/DIAG INJ SC/IM,0195-107704-0801, CEFTRIAXONE-TABUK IV,96365, THER/PROPH/DIAG IV INF INIT,9.01, Follow Up Consultation GP **Estimated Cost** :

Prescriptions:

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.
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Dr's Name : Humaira	Stamp : 	Patient 's signature{Parent : if minor} : 	Date : 28-Apr-2024
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Signature : 	Date : 28-Apr-2024
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