Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **NEEVAN NEWTON FERNANDES**	**Service Date**	**:28-Apr-2024**
Card No	: **I017-029-118947916-01**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	: **NEEVAN NEWTON FERNANDES**	**Doctor's Name**	**:Humaira**
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**		

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 : 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: **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.

Dr's Name : Humaira **Stamp :**

Signature : **Date** : 28-Apr-2024

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.

Patient 's signature{Parent if minor} : **Date :** 28-Apr-2024