Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: Narendra Mehta**	**Service Date**	**:01-May-2024**	**Network**	: Green
Card No	**: I017-029-118013012-02**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	**: Narendra Mehta**	**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	**: 07-May-1996**				
Patient's Tel No	**: 0504507830**				

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 : CO BODYACHE 2 DAYS WEAKNESS OE CHEST IS CLEAR NO ADDED SOUNDS VITALS STABLE **Duration:**

Vitals: Temp : 36.8 Bp :112 Pulse :89 Resp :22

Clinical Findings:

Diagnosis: R52 - Pain, unspecified,R53.1 - Weakness, **Date of Onset** : 01/29/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 7020-992801-1171 - (VITAMIN D (AS CHOLECALCIFEROL) : 5 MCG) (VITAMIN B12 : 2.4 MCG) (BETA CAROTENE : 1740 MCG) (MOLYBDENUM : 23 MCG) (VITAMIN C (ASCORBIC ACID) : 45 MG) (IODINE : 33 MCG) (IRON : 3.5 MG) (THIAMINE : 1.2 MG) (ZINC : 7 MG) (SELENIUM : 20 MCG) (MANGANESE : 1.8 MG) (MAGNESIUM : 120 MG) (BIOTIN : 30 MCG) (RIBOFLAVIN : 1.3 MG) (FOLIC ACID : 200 MCG) (CALCIUM : 250 MG) (VITAMIN K1 : 30 MCG) (CHROMIUM : 25 MCG) (COPPER : 0.45 MG) (PANTOTHENIC ACID : 5 MG) (VITAMIN B6 : 1.3 MG) (VITAMIN E : 4.5 MG) (NIACIN,4417-711201-0451 - (IBUPROFEN (AS L-ARGININE SALT) : 600 MG) GRANULES, **Estimated : Cost**

MEDICAL PRACTITIONER DECLARATION :

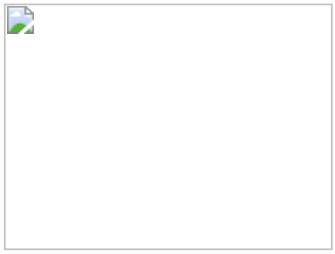
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

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 : Humaira **Stamp :** 

Patient 's signature{Parent : if minor}  **Date :** 01-May-2024

Signature :  **Date** : 01-May-2024