Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: SIDRA ZULFIQAR**	**Service Date**	**:01-May-2024**	**Network**	**:** Green
Card No	**: I017-029-117554032-02**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	**: SIDRA ZULFIQAR**	**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	**: Female**				
Date Of Birth	**: 28-Oct-1990**				
Patient's Tel No	**: 0508532894**				

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 CHEST PAIN INCREASE IN HEART BEAT OE CHEST IS CLEAR NO ADDED SOUNDS vitals stable **Duration:**

Vitals: Temp : 37.5 Bp :135 Pulse :101 Resp :22

Clinical Findings:

Diagnosis: R07.9 - Chest pain, unspecified,T78.40XS - Allergy, unspecified, sequela, **Date of Onset** :01/41/2024

Requested Investigations: 93000, ELECTROCARDIOGRAM COMPLETE,9, Consultation GP **Estimated Cost :**

Prescriptions: 0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED 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 : Humaira **Stamp :** 

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

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