Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: JOSEPH KIBE GITONGA	**Service Date**	:06-May-2024	**Network**	: Green
Card No	: I017-029-113767070-02	**Health Provider**	:Irham Medical Center Arjan	**Direct Access SP - YES**	
Policy Holder	: JOSEPH KIBE GITONGA	**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	: 01-Jan-1995				
Patient's Tel No	: 588483924				

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 : Waist painx7days Right shoulder painX 1day Generalized body aches and weaknessX1day **Duration:**

Vitals: Temp : 37 Bp :106 Pulse :84 Resp :22

Clinical Findings:

Diagnosis: M79.18 - Myalgia, other site,M54.5 - Low back pain,R53.81 - Other malaise, **Date of Onset** :06/44/2024

Requested Investigations: 0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP **Estimated Cost** :

Prescriptions: 1107-397201-2521 - (ASCORBIC ACID (VITAMIN C) : 1000 MG) (CITRUS BIOFLAVONOIDS COMPLEX : 100 MG) TIMED RELEASE TABLETS,0067-107901-1171 - (IBUPROFEN : 200 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 : Humaira

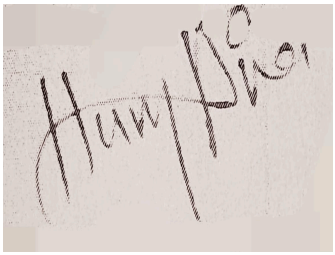
Stamp :

Dr. Humaira Mumtaz
General Practitioner
DHA No: 54155530-002
PESHAWAR MEDICAL CENTER LLC
DUBAI - U.A.E.

Patient 's signature{Parent if minor} :

Date : 06-May-2024

Signature :



Date : 06-May-2024