## Administrative MEDICAL CLAIM FORM Claim Ref:

| | | | |
|---|---|---|---|
| **Patient Name** | : **MAJEED MASIH SARDAR MASIH** | **Service Date** | **:20-May-2024** |
| **Card No** | : **I017-029-116125749-02** | **Health Provider** | **:Irham Medical Center Arjan** |
| **Policy Holder** | : **MAJEED MASIH SARDAR MASIH** | **Doctor's Name** | **:Enomen Goodluck** |
| **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** | : **03-Jan-1966** | | |
| **Patient's Tel No** | : **0505140326** | | |

**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 :** Recurrent low back pain, especially during duty hours while painting. Current episode started 3days prior to presentation. **Duration:**

**Vitals:**Temp : 36.5 Bp :147 Pulse :62 Resp :18

**Clinical Findings:**

**Diagnosis:** M54.5 - Low back pain, **Date of Onset** : 20/58/2024

**Estimated Cost** :

**Requested Investigations:** 9, Consultation GP

**Prescriptions:** 0005-378802-0151 - (DICLOFENAC SODIUM (AS DIETHYLAMINE) : 10 MG/G) CREAM,1217-373201-2401 - (TOLPERISONE : 150 MG) SUGAR COATED TABLETS,0186-143701-0061 - (CELECOXIB : 200 MG) CAPSULES,

**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** : Enomen Goodluck

**Stamp :**

Dr. Enomen Goodluck Ekata
General Practitioner
DHA No: 28040827-001
PESHAWAR MEDICAL CENTER LLC
DUBAI - U.A.E.

**Signature :**

**Date** : 20-May-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** : 20-May-2024