

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name

: MAJEED MASIH SARDAR MASIH

Card No

: I017-029-116125749-02

Policy Holder

: MAJEED MASIH SARDAR MASIH

Payer Name

: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC

TPA

: E CARE - Green Network

Validity

: 01-10-2023 To 30-09-2024

Gender

: Male

Date Of Birth

: 03-Jan-1966

Patient's Tel No

: 0505140326

Service Date

:20-May-2024

Health Provider

:Irham Medical Center Arjan

Doctor's Name

:Enomen Goodluck

Co-Insurance

Network

: Green

Direct Access SP

: YES

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

Remarks

:

☐ Acute

☐ Pre-existing and chronic

☐ Maternity

Chief Complaints

: Recurrent low back pain, especially during duty hours while painting.

Duration:

Current episode started 3days prior to presentation.

Vitals

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

Clinical Findings:

Diagnosis

: M54.5 - Low back pain,

Date of Onset

: 20/58/2024

Requested Investigations

: 9, Consultation GP

Estimated Cost

:

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.

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

: Enomen Goodluck

Stamp

:

Dr. Enomen Goodluck Ekata

General Practitioner

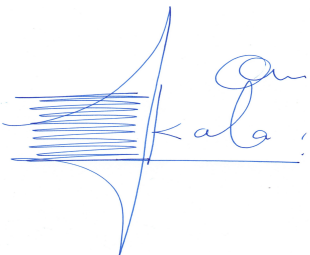
DHA No: 28040827-001

PESHAWAR MEDICAL CENTER LLC

DUBAI - U.A.E.

Signature

:



Date

: 20-May-2024

Patient 's signature{Parent : if minor}

:



20-
Date : May-
2024