Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: MANJU LAMA**	**Service Date**	**:22-May-2024**	**Network**	: Green
Card No	**: I017-029-120125902-01**	**Health Provider**	**:Irham Medical Center Arjan**	**Direct Access SP - YES**	
Policy Holder	**: MANJU LAMA**	**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	**: Female**				
Date Of Birth	**: 26-Nov-1987**				
Patient's Tel No	**: 0504625016**				

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 : Pain on the right kneel since 1bout 24hours prior to presenation. There is no history of trauma. a d pain was of insidous onstt. Exam: Tenderness on the kneel joint and ankle of right footl **Duration:**

Vitals:

Clinical Findings:

Diagnosis: M06.9 - Rheumatoid arthritis, unspecified, **Date of Onset** : 22/16/2024

Requested Investigations: 9, Consultation GP,96372, THER/PROPH/DIAG INJ SC/IM,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,86431, RHEUMATOID FACTOR QUANTITATIVE **Estimated Cost** :

Prescriptions: 0240-223401-1171 - (NAPROXEN : 500 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.

Dr's Name : Enomen Goodluck **Stamp :**

Dr. Enomen Goodluck Ekata
General Practitioner
DHA No: 20040827-001
PESHAWAR MEDICAL CENTER LLC
DUBAI - U.A.E.

Signature : **Date** : 22-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 :** 22-May-2024