Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: SOUKAINA EL HARAR**	**Service Date**	**:25-May-2024**	**Network**	**:** Green
Card No	**: I017-029-116362606-02**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	**: SOUKAINA EL HARAR**	**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	**: 14-Oct-1998**				
Patient's Tel No	**: 0507437356**				

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 : Generalized body pains, especially at the lower back. there is also associated fever this morning and dizziness with weakness. No respiratory symptoms, no GIT symptoms and no urinary symptoms. **Duration:**

Vitals: Temp : 36.9 Bp :104 Pulse :84 Resp :20

Clinical Findings:

Diagnosis: M79.10 - Myalgia, unspecified site,R50.9 - Fever, unspecified,M54.5 - Low back pain, **Date of Onset :**25/58/2024

Requested Investigations: 9, Consultation GP,81001, URNLS DIP STICK/TABLET REAGENT AUTO MICROSCOPY,86140, C REACTIVE PROTEIN **Estimated Cost :**

Prescriptions: 0349-106203-1171 - (MULTIVITAMINS : 30 MG) (MINERALS : 30 MG) TABLETS,1516-107902-1171 - (IBUPROFEN : 400 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 : Enomen Goodluck **Stamp :** Dr. Enomen Goodluck Ekata General Practitioner DHA No: 28040827-001 PESHAWAR MEDICAL CENTER LLC DUBAI - U.A.E.

Patient 's signature{Parent if minor} : **Date :** 25-May-2024

Signature : **Date :** 25-May-2024