Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **BABINA LAMA BIRENDRA BAHADUR LAMA**	**Service Date**	**:11-Jun-2024**	**Network**	: Green
Card No	: **I017-029-117170241-02**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	: **BABINA LAMA BIRENDRA BAHADUR 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-Apr-1995**				
Patient's Tel No	: **0502325464**				

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 in the left lower limb, said to radiate from the low back down the left lower limb up to the kneel joint region. There is no tingling sensation nor numbness. Duration is 3days (08/06/2024). She has no previous medical condition, she is not hypertensive and not diabetic. **Duration:**

Vitals: Temp : 37.5 Bp :110 Pulse :76 Resp :18

Clinical Findings:

Diagnosis: M54.32 - Sciatica, left side,M54.5 - Low back pain, **Date of Onset** : 11/23/2024

Requested Investigations: 96372, THER/PROPH/DIAG INJ SC/IM,0005-149902-1021, CLOFEN ,9, Consultation GP **Estimated Cost** :

Prescriptions: 0027-142201-0832 - (DICLOFENAC POTASSIUM : 50 MG) POWDER FOR SOLUTION,1217-373201-2401 - (TOLPERISONE : 150 MG) SUGAR COATED 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: 28040827-001
PESHAWAR MEDICAL CENTER LLC
DUBAI - U.A.E.

Signature : **Date** : 11-Jun-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 :** 11-Jun-2024