Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **NABIL AHMED SHAIKH NISAR AHMAD SHAIKH**	**Service Date**	**:13-Jun-2024**	**Network**	: Green
Card No	: **I017-029-119467325-01**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	: **NABIL AHMED SHAIKH NISAR AHMAD SHAIKH**	**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	: **09-Jul-2000**				
Patient's Tel No	: **0589235069**				

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 ear and also buzzing sounds No complaint with right ear. Uses headset alot. PMHx: Celiac disease ENT: wax in the left ear. Right ear however shows old ruptured TM. **Duration:**

Vitals: Temp : 36 Bp :120 Pulse :76 Resp :18

Clinical Findings:

Diagnosis: H61.22 - Impacted cerumen, left ear,M25.512 - Pain in left shoulder,H92.02 - Otalgia, left ear,M43.6 - Torticollis,M54.2 - Cervicalgia, **Date of Onset** :14/43/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 1217-373201-2401 - (TOLPERISONE : 150 MG) SUGAR COATED TABLETS,0027-142201-0832 - (DICLOFENAC POTASSIUM : 50 MG) POWDER FOR SOLUTION,0355-163001-0241 - (DOCUSATE :0.5%) EAR DROPS, **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** : 14-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 :** 14-Jun-2024