Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **HRIDAY WADHWA KAMAL HARIRAM WADHWA**	**Service Date**	**:02-Aug-2024**	**Network**	: Green
Card No	: **I017-029-120176865-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**		**Direct Access SP - YES**
Policy Holder	: **HRIDAY WADHWA KAMAL HARIRAM WADHWA**	**Doctor's Name**	**:AHSAN HUSSAIN**		
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	: **26-Mar-1999**				
Patient's Tel No	: **0522715010**				

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 : PC: PAIN JAW TMJ **Duration :**

Vitals: Temp : 36.9 Bp :100 Pulse :86 Resp :18

Clinical Findings:

Diagnosis: R68.84 - Jaw pain, **Date of Onset** : 02/32/2024

Requested Investigations: 0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP **Estimated Cost :**

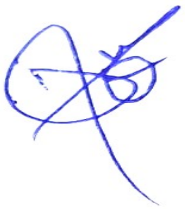
Prescriptions: 0027-266002-1171 - (TIZANIDINE : 2 MG) TABLETS,4179-711202-0391 - (IBUPROFEN (AS L-ARGININE SALT) : 400 MG) FILM COATED TABLETS, **Estimated Cost :**

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 : AHSAN HUSSAIN **Stamp :**

Signature :



Date : 02-Aug-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 : 02-Aug-2024