Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **ARIFUL ISLAM MOHAMED MOFIZUL ISLAM**	**Service Date**	**:22-Oct-2023**	**Network**	: Green
Card No	: **I017-029-117170354-02**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	: **ARIFUL ISLAM MOHAMED MOFIZUL ISLAM**	**Doctor's Name**	**:Sajid Sanaullah**		
Payer Name	: **ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:		
TPA	: **E CARE - Blue Network**	**Remarks**	:		
Validity	: **01-10-2023** To **30-09-2024**				
Gender	: **Male**				
Date Of Birth	: **05-Jul-1986**				
Patient's Tel No	: **0554435294**				

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 : C/o Low back pain on and off since 1 month aggravated since 2 days **Duration :**

Vitals: Temp : 37.1 Bp :110 Pulse :90 Resp :20

Clinical Findings:

Diagnosis: M54.5 - Low back pain,M54.9 - Dorsalgia, unspecified, **Date of Onset** : 22/53/2023

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

Prescriptions: 7070-149919-0431 - (DICLOFENAC SODIUM : 1 G/100G) GEL,0186-143702-0061 - (CELECOXIB : 100 MG) CAPSULES, **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 : Sajid Sanaullah **Stamp :**

Dr. Sajid Sanaullah Khan
General Practitioner
DHA No: 05758224-001
PESHAWAR MEDICAL CENTER LLC
DUBAI - U.A.E.

Patient 's signature{Parent : if minor} **Date :** 22-Oct-2023

Signature : **Date** : 22-Oct-2023