Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: BENYAM TSEGAYE FEREDE**	**Service Date**	**:29-Nov-2023**	**Network**	**:** Green
Card No	**: I017-029-118261026-02**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	**: BENYAM TSEGAYE FEREDE**	**Doctor's Name**	**:Sajid Sanaullah**		
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	**: 20-Feb-1990**				
Patient's Tel No	**: 0502607628**				

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 : left side lower back pain from 27 11 2023 pain too severe cant move properly but does not radiate to legs past history is unremarkable **Duration:**

Vitals: Temp : 36.5 Bp :115 Pulse :88 Resp :21

Clinical Findings:

Diagnosis: M54.5 - Low back pain,G89.11 - Acute pain due to trauma, **Date of Onset** **:** 29/20/2023

Requested Investigations: 9, Consultation GP **Estimated Cost** **:**

Prescriptions: **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 :** 29-Nov-2023

Signature : **Date** **:** 29-Nov-2023