

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : KHARAK SINGH KISHAN SINGH
Card No : I017-029-119076401-01
Policy Holder : KHARAK SINGH KISHAN SINGH
Payer Name : ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC
TPA : E CARE - Green Network
Validity : 01-10-2023 To 30-09-2024
Gender : Male
Date Of Birth : 15-Jul-1998
Patient's Tel No : 0569469783

Service Date : 03-Dec-2023
Health Provider : Irham Medical Center Arjan
Doctor's Name : Sajid Sanaullah
Co-Insurance :

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

Network : Green
Direct Access SP - YES

Remarks :

☐ Acute
 ☐ Pre-existing and chronic
 ☐ Maternity

Chief Complaints : back pain and spasm from 2/12/2023 in thoracic paraspinal muscle **Duration :**

Vitals: Temp : 1 Bp : 100 Pulse : 82 Resp : 19

Clinical Findings:

Diagnosis: M62.830 - Muscle spasm of back, M62.838 - Other muscle spasm, **Date of Onset :** 03/16/2023

Requested Investigations: 0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE, 0005-149902-1021, CLOFEN , 96372, THER/PROPH/DIAG INJ SC/IM, 9, Consultation GP

Estimated Cost :

Prescriptions: 7070-149919-0431 - (DICLOFENAC SODIUM : 1 G/100G) GEL, **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 :



Patient's signature {Parent : if minor}



Date : 03-Dec-2023

Signature :

Date : 03-Dec-2023