

Administrative

MEDICAL CLAIM FORM

Claim Ref:

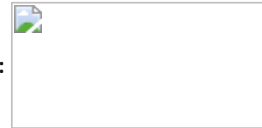
Patient Name : MANSOOR PERINGODAN
Card No : I017-029-118774233-01
Policy Holder : MANSOOR PERINGODAN
Payer Name : ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC
TPA : E CARE - Green Network
Validity : 01-01-1900 To 30-09-2024
Gender : Male
Date Of Birth : 30-May-1985
Patient's Tel No : 971566442706

Service Date : 11-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 : severe low back pain started one month before on 10/11/2023 and today increased in intensity without any trauma and history Duration:		
Vitals: Temp : 36.6 Bp :120 Pulse :67 Resp :19		
Clinical Findings:		
Diagnosis: M54.5 - Low back pain,M54.40 - Lumbago with sciatica, unspecified side,M62.830 - Muscle spasm of back,		Date of Onset : 11/08/2023
Requested Investigations: 0005-149902-1021, CLOFEN ,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP		Estimated Cost :
Prescriptions: 1217-373201-2401 - (TOLPERISONE : 150 MG) SUGAR COATED TABLETS,7070-149919-0431 - (DICLOFENAC SODIUM : 1 G/100G) GEL,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.		
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} 
Signature : 	Date : 11-Dec-2023	Date : 11-Dec-2023