

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : VIRAJ PRAVEERA GARDHI HEWAWASAM
Card No : I017-029-118236870-02
Policy Holder : VIRAJ PRAVEERA GARDHI HEWAWASAM
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 : 03-Jun-1991
Patient's Tel No : 0524501511

Service Date : 23-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 : knee pain with normal flex and extension active pain positive and negative inDuration: passive range of motion

Vitals:Temp : 36.5 Bp :120 Pulse :88 Resp :22

Clinical Findings:

Diagnosis: M25.561 - Pain in right knee,R52 - Pain, unspecified,M79.10 - Myalgia, unspecified site,M13.861 - Other specified arthritis, right knee, **Date of Onset :** 23/12/2023

Requested Investigations: 85652, SEDIMENTATION RATE RBC AUTOMATED,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,82306, 25 HYDROXY BLOOD,82310, CALCIUM TOTAL,83735, MAGNESIUM,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,0102-100104-1001, SODIUM CHLORIDE & DEXTROSE B.P.-(SODIUM CHLORIDE : 0.9%) (DEXTROSE : 5%) SOLUTION FOR INFUSION,0248-122107-1021, DEXAMETHASONE SODIUM PHOSPHATE ,96365, THER/PROPH/DIAG IV INF INIT,96374, THER/PROPH/DIAG INJ IV PUSH,9, Consultation GP

**Estimated :
Cost**

Prescriptions: 5101-640418-0061 - (VITAMIN D3 (CHOLECALCIFEROL) : 1000 IU) CAPSULES,1132-280402-0151 - (CAPSAICIN : 25 MG) CREAM,2027-560101-0392 - (IBUPROFEN : 150 MG) (PARACETAMOL : 500 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 :

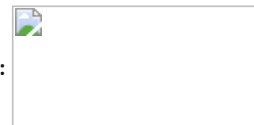
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Sajid Sanaullah

Stamp :



Patient 's signature{Parent : if minor}



Date : 23-Dec-2023

Signature :

Date : 23-Dec-2023