Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **VIRAJ PRAVEERA GARDHI HEWAWASAM**	**Service Date**	**:23-Dec-2023**	**Network**	: Green
Card No	: **I017-029-118236870-02**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	: **VIRAJ PRAVEERA GARDHI HEWAWASAM**	**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	: **03-Jun-1991**				
Patient's Tel No	: **0524501511**				

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 : knee pain with normal flex and extension active pain positive and negative in passive range of motion **Duration:**

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 INCLUDES FRACTIONS IF PERFORMED,84520, UREA NITROGEN QUANTITATIVE,82565, CREATININE 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 :**

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 :** 23-Dec-2023

Signature :  **Date** : 23-Dec-2023