Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: PRASANTH SELVARAJAH**	**Service Date**	**:03-Feb-2024**	**Network**	**:** Green
Card No	**: I017-029-117672857-02**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	**: PRASANTH SELVARAJAH**	**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	**: 10-Jun-1997**				
Patient's Tel No	**: 971503593847**				

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 : C/o: Back pain since one week (27/01/2023). Pain gets worse following heavy lifting. **Duration:**

Vitals: Temp : 36 Bp :127 Pulse :82 Resp :20

Clinical Findings:

Diagnosis: M54.5 - Low back pain,M47.897 - Other spondylosis, lumbosacral region,B36.9 - Superficial mycosis, unspecified, **Date of Onset** :03/37/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0207-214402-0151 - (BETAMETHASONE : N/A) (CLOTRIMAZOLE : N/A) CREAM,2093-596002-0432 - (DICLOFENAC DIETHYLAMINE : 23.2 MG / G) GEL,0027-142201-0831 - (DICLOFENAC POTASSIUM : 50 MG) POWDER FOR SOLUTION, **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-Feb-2024

Signature :

Date : 03-Feb-2024