Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **ANUHAS KITHUN OSHAN HETTIARACHCHI**	**Service Date**	**:15-Feb-2024**
Card No	: **I017-029-117741005-02**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	: **ANUHAS KITHUN OSHAN HETTIARACHCHI**	**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	: **29-Mar-1997**		
Patient's Tel No	: **0563273536**		

Network : Green

Direct Access SP - YES

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: Pain on the left side of the neck with aassociated stiffness and difficulty turning. Started 2 weeks ago but spontaneously resolving as it has now got better. Now has developed similar pain on the right shoulder and upper arm and pain is severe scored as 9/10. ' There is no history of trauma, no fever, no known relieving nor aggravating factor, has no previous medical conditions, not hypertensive and not diabetic.

Duration:

Vitals: Temp : 36.7 Bp :124 Pulse :82 Resp :18

Clinical Findings:

Diagnosis: M60.10 - Interstitial myositis of unspecified site,M54.2 - Cervicalgia,M25.511 - Pain in right shoulder,G24.3 - Spasmodic torticollis,

Date of Onset :15/30/2024

Requested Investigations: 9, Consultation GP,82550, CREATINE KINASE TOTAL,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,85652, SEDIMENTATION RATE RBC AUTOMATED

Estimated Cost :

Prescriptions: 0619-149914-0741 - (DICLOFENAC SODIUM : 140 MG) PLASTER,0027-149903-0111 - (DICLOFENAC SODIUM : 100 MG) COATED TABLETS,1217-373201-2401 - (TOLPERISONE : 150 MG) SUGAR 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 : 15-Feb-2024

Signature :

Date : 15-Feb-2024