Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **LAXMI NARAIN BRIJ RAJ PANDEY**	**Service Date**	:**17-Feb-2024**
Card No	: **I005-029-115888506-01**	**Health Provider**	:**Irham Medical Center Arjan**
Policy Holder	: **LAXMI NARAIN BRIJ RAJ PANDEY**	**Doctor's Name**	:**Sajid Sanaullah**
Payer Name	: **DUBAI INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **25-08-2023** To **24-08-2024**		
Gender	: **Male**		
Date Of Birth	: **11-Aug-1965**		
Patient's Tel No	: **0555756569**		

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: Recurrent low back pain for the past one year. Pain is more on the left side and radiates down the left lower limb. There is no urinary symptoms and has no tingling nor weakness of the lower limb. He is a known hypertensive not compliant with medications. **Duration:**

Vitals: Temp : 36.7 Bp :140 Pulse :84 Resp :22

Clinical Findings:

Diagnosis: M54.5 - Low back pain,M47.897 - Other spondylosis, lumbosacral region,M54.32 - Sciatica, left side,I10 - Essential (primary) hypertension,K21.00 - Gastro-esophageal reflux dis with esophagitis, without bleed, **Date of Onset** :17/00/2024

Requested Investigations: 72148, MRI SPINAL CANAL LUMBAR W/O CONTRAST MATERIAL,96372, THER/PROPH/DIAG INJ SC/IM,0005-149902-1021, CLOFEN ,9, Consultation GP **Estimated Cost** :

Prescriptions: 2093-596002-0432 - (DICLOFENAC DIETHYLAMINE : 23.2 MG / G) GEL,0071-155104-1171 - (AMLODIPINE : 5 MG) (PERINDOPRIL : 10 MG) TABLETS,0188-232401-0392 - (ESOMEPRAZOLE : 40 MG) FILM COATED TABLETS,0005-225601-1171 - (PARACETAMOL : 450 MG) (ORPHENADRINE : 35 MG) TABLETS,0090-122303-0392 - (ETORICOXIB : 90 MG) FILM 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 : 17-Feb-2024

Signature :

Date : 17-Feb-2024