Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: ANKUSH SHARMA KHEMRAJ**	**Service Date**	**:28-Feb-2024**	**Network**	**:** Green
Card No	**: I017-029-119467326-01**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	**: ANKUSH SHARMA KHEMRAJ**	**Doctor's Name**	**:Sajid Sanaullah**		
Payer Name	**: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	**:**		
TPA	**: E CARE - Green Network**				
Validity	**: 01-10-2023** To **30-09-2024**				
Gender	**: Male**	**Remarks**	**:**		
Date Of Birth	**: 17-Mar-1992**				
Patient's Tel No	**: 0522159638**				

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 IN LOWER BACK SINCE 1 DAY **Duration :**

Vitals: Temp : 37.6 Bp :119 Pulse :86 Resp :18

Clinical Findings:

Diagnosis: R25.2 - Cramp and spasm,R52 - Pain, unspecified, **Date of Onset :** 28/47/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0027-378802-0433 - (DICLOFENAC SODIUM (AS DIETHYLAMINE) : 10 MG/G) GEL, 0701-180401-0431 - (KETOPROFEN : 2.5%) GEL,0717-226501-2401 - (EPERISONE : 50 MG) SUGAR COATED TABLETS,2027-560101-0391 - (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

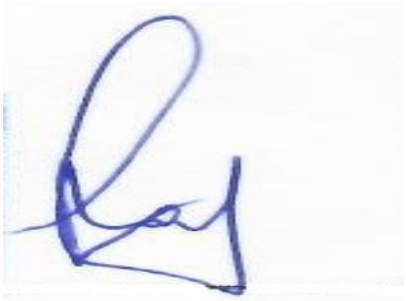
Stamp :

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 : 28-Feb-2024

Signature :



Date : 28-Feb-2024