

Administrative

Patient Name : MOHAMED SAFNI

Card No : I017-029-120076119-01

Policy Holder : MOHAMED SAFNI

Payer Name : ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC

TPA : E CARE - Green Network

Validity : 13-11-2023 To 30-09-2024

Gender : Male

Date Of Birth : 01-Nov-2000

Patient's Tel No : 0565727014

Service Date :29-Feb-2024

Health Provider :Irham Medical Center Arjan

Doctor's Name :Sajid Sanaullah

Co-Insurance :

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

Remarks :

Network : Green

Direct Access SP - YES

☐ Acute

☐ Pre-existing and chronic

☐ Maternity

Chief Complaints : C/o: Right shoulder pain, associated weakness on the right upper limb and numbness on on the right thumb. This first happen 3months ago after a gym session and has since then been recurrent whenever he goes to the gym. There is no fever, no neck pain and no neurologic deficit.

Duration:

Vitals:Temp : 36.7 Bp :105 Pulse :82 Resp :18

Clinical Findings:

Diagnosis: M47.22 - Other spondylosis with radiculopathy, cervical region,M25.511 - Pain in right shoulder,M79.2 - Neuralgia and neuritis, unspecified,E53.9 - Vitamin B deficiency, unspecified,

Date of Onset :29/36/2024

Requested Investigations: 9, Consultation GP

Estimated Cost :

Prescriptions: 0321-100604-1171 - (VITAMIN B12 : 200 MCG) (THIAMINE (VITAMIN B1) : 100 MG) (PYRIDOXINE (VITAMIN B6) : 200 MG) TABLETS,2093-596002-0432 - (DICLOFENAC DIETHYLAMINE : 23.2 MG / G) GEL,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.

Dr's Name : Sajid Sanaullah

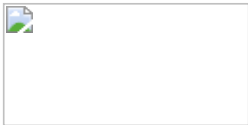
Stamp :

Dr. Sajid Sanaullah Khan
General Practitioner
DHA No: 05758224-001
PESHAWAR MEDICAL CENTER LLC
DUBAI - U.A.E.

Signature :

Date : 29-Feb-2024

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.

Patient 's signature{Parent : if minor}

Date : Feb-2024

https://irhamc.visionsoftwares.ae/mr_ecare_claim_print.aspx?appld=46623&patId=52152

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