Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: MOHAMED SAFNI**	**Service Date**	**:29-Feb-2024**	**Network**	**:** Green
Card No	**: I017-029-120076119-01**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	**: MOHAMED SAFNI**	**Doctor's Name**	**:Sajid Sanaullah**		
Payer Name	**: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:		
TPA	**: E CARE - Green Network**	**Remarks**	:		
Validity	**: 13-11-2023** To **30-09-2024**				
Gender	**: Male**				
Date Of Birth	**: 01-Nov-2000**				
Patient's Tel No	**: 0565727014**				

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: Right shoulder pain, associated weakness on the right upper limb and numberness 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

Estimated Cost :

Requested Investigations: 9, Consultation GP

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.

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 : 29-Feb-2024

Signature :

Date : 29-Feb-2024