Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: PRABIN PONNU MUTHU**	**Service Date**	**:15-Mar-2024**	**Network**	**:** Green
Card No	**: I017-029-119503552-01**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	**: PRABIN PONNU MUTHU**	**Doctor's Name**	**:Maimoona**		
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	**: 25-Dec-1989**				
Patient's Tel No	**: 0558032946**				

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 lower back pain since 5 days **Duration :**

Vitals: Temp : 35 Bp :120` Pulse :75 Resp :0

Clinical Findings:

Diagnosis: M54.5 - Low back pain, **Date of Onset** : 15/07/2024

Requested Investigations: 9, Consultation GP **Estimated Cost :**

Prescriptions: 2093-596002-0431 - (DICLOFENAC DIETHYLAMINE : 23.2 MG / G) GEL, 0027-142201-0831 - (DICLOFENAC POTASSIUM : 50 MG) POWDER FOR SOLUTION, **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 : Maimoona **Stamp :**

Patient 's signature{Parent : if minor}

Date : 15-Mar-2024

Signature :

Date : 15-Mar-2024