

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : PRABIN PONNU MUTHU

Card No : I017-029-119503552-01

Policy Holder : PRABIN PONNU MUTHU

Payer Name : ABU DHABI NATIONAL
INSURANCE COMPANY-ADNIC

TPA : E CARE - Green Network

Validity : 01-10-2023 To 30-09-2024

Gender : Male

Date Of Birth : 25-Dec-1989

Patient's Tel No : 0558032946

Service Date : 15-Mar-2024

Network : Green

Health Provider : Irham Medical Center Arjan

Direct Access SP - YES

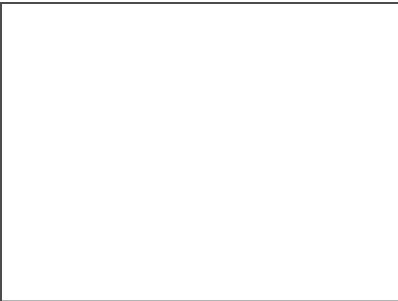
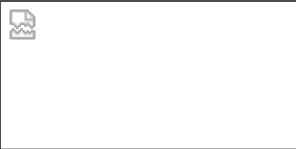
Doctor's Name : Maimoona

Co-Insurance :

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

Remarks :

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

Signature :		Date : 15-Mar-2024		Patient 's signature{Parent : if minor}		Date : 15- Mar-2024