Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: RAM BAHADUR PARIYAR**	**Service Date**	**:15-Mar-2024**	**Network**	**:** Green
Card No	**: I017-029-119055710-01**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	**: RAM BAHADUR PARIYAR**	**Doctor's Name**	**:Enomen Goodluck**		
Payer Name	**: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:		
TPA	**: E CARE - Green Network**	**Remarks**	:		
Validity	**: 01-10-2023** To **30-09-2024**				
Gender	**: Male**				
Date Of Birth	**: 03-May-1982**				
Patient's Tel No	**: 0504266519**				

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 on both feet, worst on the right foot. Also weakness, and tiredness **Duration:**
Has history of hyperuricemia. Frequency of urine and nocturia of 3 times per night.

Vitals: Temp : 36.8 Bp :140 Pulse :82 Resp :22

Clinical Findings:

Diagnosis: M10.9 - Gout, unspecified,E11.42 - Type 2 diabetes mellitus with diabetic polyneuropathy,E55.9 - Vitamin D deficiency, unspecified,M79.671 - Pain in right foot,M79.2 - Neuralgia and neuritis, unspecified, **Date of Onset** :15/44/2024

Requested Investigations: 9, Consultation GP,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,82947, GLUCOSE QUANTITATIVE BLOOD XCPT REAGENT STRIP,83036, HEMOGLOBIN GLYCOSYLATED A1C,84550, URIC ACID BLOOD,84591, VITAMIN NOT OTHERWISE SPECIFIED,86140, C REACTIVE PROTEIN **Estimated Cost** :

Prescriptions: 5254-830602-2401 - (VITAMIN B1 (THIAMINE) : 100 MG) (VITAMIN B6 (AS PYRIDOXINE HCL) : 200 MG) (VITAMIN B12 (CYANOCOBALAMIN) : 200 MCG) SUGAR COATED TABLETS,0426-160701-2541 - (METHYL SALICYLATE : N/A) (HYDROXYETHYL SALICYLATE : N/A) (ETHYL SALICYLATE : N/A) (METHYL NICOTINATE : N/A) TOPICAL AEROSOL SPRAY,0027-149903-0391 - (DICLOFENAC SODIUM : 100 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.

Dr's Name : Enomen Goodluck **Stamp :**

Dr. Enomen Goodluck Ekata
General Practitioner
DHA No: 20040827-001
PESHAWAR MEDICAL CENTER LLC
DUBAI : U.A.E.

Signature : **Date** : 15-Mar-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 :** 15-Mar-2024