Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **SUSHIL POUDEL GOVINDA POUDEL**	**Service Date**	:**26-Mar-2024**	**Network**	: Green
Card No	: **I040-029-119078847-01**	**Health Provider**	:**Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	: **SUSHIL POUDEL GOVINDA POUDEL**	**Doctor's Name**	:**Enomen Goodluck**		
Payer Name	: **UNION INSURANCE COMPANY**	**Co-Insurance**	:		
TPA	: **E CARE - Blue Network**	**Remarks**	:		
Validity	: **02-01-2024** To **01-01-2025**				
Gender	: **Male**				
Date Of Birth	: **26-Nov-1996**				
Patient's Tel No	: **0559627904**				

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 : Kneel joint pains on both lower limbs. Pain is worst in the mornings on waking. No history of trauma. Associated lower back pain. Works as a house keeper in the hotel and job is stressful Counselled on the need for weight loss. **Duration:**

Vitals: Temp : 37.1 Bp :120 Pulse :84 Resp :18

Clinical Findings:

Diagnosis: M17.0 - Bilateral primary osteoarthritis of knee,M47.896 - Other spondylosis, lumbar region,M54.5 - Low back pain, **Date of Onset** :26/56/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 1217-373201-2401 - (TOLPERISONE : 150 MG) SUGAR COATED TABLETS,0090-122303-0392 - (ETORICOXIB : 90 MG) FILM COATED TABLETS,2093-596002-0432 - (DICLOFENAC DIETHYLAMINE : 23.2 MG / G) GEL, **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 : Enomen Goodluck **Stamp :**

Dr. Enomen Goodluck Ekata
General Practitioner
DHA No: 28040827-001
PESHAWAR MEDICAL CENTER LLC
DUBAI : U.A.E.

Patient 's signature{Parent if minor} : **Date** : 26-Mar-2024

Signature : **Date** : 26-Mar-2024