Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: AYUSH YONZON LAMA**	**Service Date**	**:30-Mar-2024**
Card No	**: I017-029-116591791-02**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	**: AYUSH YONZON LAMA**	**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	**: 27-Mar-1994**		
Patient's Tel No	**: 0508158396**		

Network : Green

Direct Access SP - YES

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 in the back of sudden onset while lifting a heavy load at work earlier today. Pain is located at about T12/L1 level. **Duration:**

Vitals: Temp : 36.7 Bp :111 Pulse :82 Resp :22

Clinical Findings:

Diagnosis: M54.5 - Low back pain, **Date of Onset** : 30/01/2024

Requested Investigations: 9, Consultation GP,96372, THER/PROPH/DIAG INJ SC/IM,0005-149902-1021, CLOFEN **Estimated Cost** :

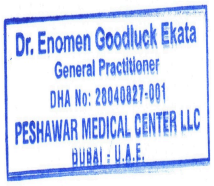
Prescriptions: 1217-373201-2401 - (TOLPERISONE : 150 MG) SUGAR COATED TABLETS,2093-596002-0432 - (DICLOFENAC DIETHYLAMINE : 23.2 MG / G) GEL,0027-149903-0391 - (DICLOFENAC SODIUM : 100 MG) FILM COATED TABLETS, **Estimated Cost** :

MEDICAL PRACTITIONER DECLARATION :

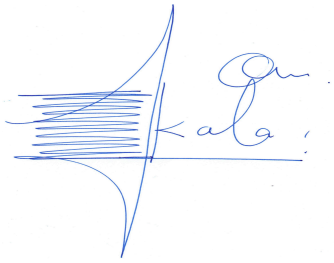
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

Dr's Name : Enomen Goodluck

Stamp :



Signature :



Date : 30-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 : 30-Mar-2024