Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: SAMANLATHA UDAYANGANI PUSHPA KUMARI KANDEDURA ARACHCHILAGE**	**Service Date**	**:22-Apr-2024**	**Network**	**:** Green
Card No	**: I022-029-120013926-01**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	**: SAMANLATHA UDAYANGANI PUSHPA KUMARI KANDEDURA ARACHCHILAGE**	**Doctor's Name**	**:Humaira**		
Payer Name	**: TAKAFUL EMARAT**	**Co-Insurance**	**:**		
TPA	**: E CARE - Blue Network**	**Remarks**	**:**		
Validity	**: 18-10-2023** To **17-10-2024**				
Gender	**: Female**				
Date Of Birth	**: 17-Dec-1989**				
Patient's Tel No	**: 05517630338**				

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 : co pain in both sides of neck 2 days pain in back sacral region oe sever streching pain in both sides of neck moderate pain in the back sacral region chest is clear vital stable **Duration:**

Vitals: Temp : 37.1 Bp :108 Pulse :76 Resp :18

Clinical Findings:

Diagnosis: M62.830 - Muscle spasm of back,S16.1XXS - Strain of muscle, fascia and tendon at neck level, sequela,F41.1 - Generalized anxiety disorder, **Date of Onset** :22/21/2024

Requested Investigations: 9, Consultation GP,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,96372, THER/PROPH/DIAG INJ SC/IM **Estimated Cost** :

Prescriptions: 0095-238001-0171 - (DICLOFENAC ACID : 46.5MG) DISPERSIBLE TABLETS,2093-596002-0432 - (DICLOFENAC DIETHYLAMINE : 23.2 MG / G) GEL,1217-373201-2401 - (TOLPERISONE : 150 MG) SUGAR 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.

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 : Humaira **Stamp :** 

Patient 's signature{Parent if minor} :  **Date :** 22-Apr-2024

Signature :  **Date :** 22-Apr-2024