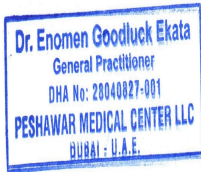
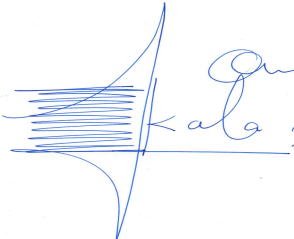


Claim Ref:

Patient Name	: DALIP SINGH UMESH SINGH	Service Date	:23-Apr-2024	Network	: Green												
Card No	: I017-029-119293445-01	Health Provider	:Irham Medical Center Arjan	Direct Access SP - YES													
Policy Holder	: DALIP SINGH UMESH SINGH	Doctor's Name	:Enomen Goodluck														
Payer Name	ABU DHABI NATIONAL : INSURANCE COMPANY-ADNIC	Co-Insurance	<table><tr><td>CONSULTATION</td><td>LAB/RADIOLOGY</td><td>PHYSIO</td><td>PHARMACY</td><td>IP</td><td>MATERNITY</td></tr><tr><td>10% max</td><td>NIL</td><td>NIL</td><td>NIL LIMIT</td><td>NIL</td><td>10%</td></tr></table>			CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	10% max	NIL	NIL	NIL LIMIT	NIL	10%
CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY												
10% max	NIL	NIL	NIL LIMIT	NIL	10%												
TPA	: E CARE - Green Network	Remarks	:														
Validity	: 01-10-2023 To 30-09-2024																
Gender	: Male																
Date Of Birth	: 20-Jun-1995																
Patient's Tel No	: 0502052706																

☐ Acute		☐ Pre-existing and chronic		☐ Maternity	
Chief Complaints : Pain on the right hip joint since yesterday morning. There is no history of trauma and this is the first time he is having this kind of problem Not hypertensive and not diabetic. Works as a chef and stands for 12 hours every day cooking.					
Duration:					
Vitals:					
Clinical Findings:					
Diagnosis: M16.11 - Unilateral primary osteoarthritis, right hip,M25.551 - Pain in right hip,				Date of Onset :23/46/2024	
Requested Investigations: 96372, THER/PROPH/DIAG INJ SC/IM,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,0005-149902-1021, CLOFEN ,9, Consultation GP				Estimated Cost :	
Prescriptions: 0005-119803-1171 - (PREDNISOLONE : 20 MG) TABLETS,0426-160701-2541 - (METHYL SALICYLATE : N/A) (HYDROXYETHYL SALICYLATE : N/A) (ETHYL SALICYLATE : N/A) (METHYL NICOTINATE : N/A) TOPICAL AEROSOL SPRAY,0135-223401-1171 - (NAPROXEN : 500 MG) TABLETS,				Estimated Cost :	
MEICAL 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 : 		Patient 's signature{Parent : if minor} 	
Signature : 		Date : 23-Apr-2024			