Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **RAVINDRA SINGH KUWAR SINGH**	**Service Date**	**:30-Apr-2024**	**Network**	: Green
Card No	: **I017-029-119843965-01**	**Health Provider**	**:Irham Medical Center Arjan**	**Direct Access SP - YES**	
Policy Holder	: **RAVINDRA SINGH KUWAR SINGH**	**Doctor's Name**	**:Humaira**		
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	: **16-Jun-1987**				
Patient's Tel No	: **0521136987**				

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 muscle stretch of rt leg painfull 1 month on and off oe chest is clear no added sounds vitals stable **Duration:**

Vitals: Temp : 37.1 Bp :122 Pulse :66 Resp :22

Clinical Findings:

Diagnosis: M62.831 - Muscle spasm of calf,R52 - Pain, unspecified, **Date of Onset** : 30/37/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0027-378802-0433 - (DICLOFENAC SODIUM (AS DIETHYLAMINE) : 10 MG/G) GEL,1217-373201-2401 - (TOLPERISONE : 150 MG) SUGAR COATED TABLETS,4417-711202-0391 - (IBUPROFEN (AS L-ARGININE SALT) : 400 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.

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 :** 30-Apr-2024

Signature :  **Date** : 30-Apr-2024