Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **Nimesh Kavinda Fernando Warnakulasuriya Patabadige**	**Service Date**	**:28-May-2024**	**Network**	: Green
Card No	: **I017-029-116122358-02**	**Health Provider**	**:Irham Medical Center Arjan**	**Direct Access SP - YES**	
Policy Holder	: **Nimesh Kavinda Fernando Warnakulasuriya Patabadige**	**Doctor's Name**	**:Humaira**		
Payer Name	: **ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:		
TPA	: **E CARE - Green Network**	**Remarks**	:		
Validity	: **01-01-1900** To **30-09-2024**				
Gender	: **Male**				
Date Of Birth	: **22-Oct-1997**				
Patient's Tel No	: **0582312609**				

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 cold pain in throat fever bodyACHE cough dry 2 days epigastric pain 1month on and off oe enlarge tonsills chest is congested no added sounds stable **Duration:**

Vitals: Temp : 36.3 Bp :131 Pulse :83 Resp :18

Clinical Findings:

Diagnosis: J03.90 - Acute tonsillitis, unspecified,K29.70 - Gastritis, unspecified, without bleeding,R50.9 - Fever, unspecified,R05 - Cough,J06.9 - Acute upper respiratory infection, unspecified, **Date of Onset** :28/27/2024

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,85652, SEDIMENTATION RATE RBC AUTOMATED,0195-107704-0801, CEFTRIAXONE-TABUK IV,96374, THER/PROPH/DIAG INJ IV PUSH,9, Consultation GP **Estimated Cost** :

Prescriptions: 0669-533802-0391 - (ESOMEPRAZOLE (AS MAGNESIUM) : 40 MG) FILM COATED TABLETS,0207-169703-1161 - (AMMONIUM CHLORIDE : N/A) (DIPHENHYDRAMINE : N/A) SYRUP,0005-107001-0051 - (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,0139-116206-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) 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.

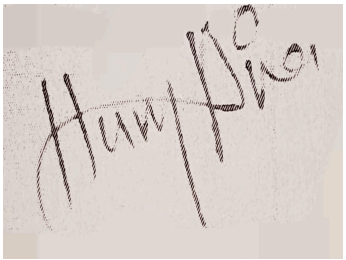
Dr's Name : Humaira

Stamp :

Dr. Humaira Mumtaz
General Practitioner
DHA No: 54155530-002
PESHAWAR MEDICAL CENTER LLC
DUBAI - U.A.E.

Patient 's signature{Parent if minor} :

Date : 28-May-2024

Signature : 

Date : 28-May-2024