Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: DILAN SAMALKA SENANAYAKE KALUTARA KORALALAGE**
Card No	**: I017-029-117490343-02**
Policy Holder	**: DILAN SAMALKA SENANAYAKE KALUTARA KORALALAGE**
Payer Name	**: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**
TPA	**: E CARE - Green Network**
Validity	**: 01-10-2023** To **30-09-2024**
Gender	**: Male**
Date Of Birth	**: 18-Sep-1990**
Patient's Tel No	**: 0522946517**

Service Date **:05-Jun-2024** **Network** : Green

Health Provider **:Irham Medical Center Arjan** **Direct Access SP - YES**

Doctor's Name **:Humaira**

Co-Insurance :

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

Remarks :

☐ **Acute** ☐ **Pre-existing and chronic** ☐ **Maternity**

Chief Complaints : co cough dry pain in the chest headache pain inthe abdomen 3 days oe enlarge tonsills epigastric pain chest is wheezing no added sounds smoker **Duration:**

Vitals: Temp : 36.6 Bp :110 Pulse :84 Resp :18

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,R05 - Cough,R07.1 - Chest pain on breathing,K29.00 - Acute gastritis without bleeding, **Date of Onset** :05/33/2024

Requested Investigations: 9, Consultation GP,0195-107704-0801, CEFTRIAXONE-TABUK IV,96374, THER/PROPH/DIAG INJ IV PUSH,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,85652, SEDIMENTATION RATE RBC AUTOMATED,0188-135906-2441, PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION,94640, AIRWAY INHALATION TREATMENT,INJ018, INJ-HYDROCORTISONE 500MG/4ML **Estimated Cost** :

Prescriptions: 0097-393801-2471 - (AMMONIUM CHLORIDE : 131.5 MG/5 ML) (DIPHENHYDRAMINE HCL : 13.5 MG/5ML) SYRUP (ALCOHOL FREE),0005-119803-1171 - (PREDNISOLONE : 20 MG) TABLETS,0188-232401-0391 - (ESOMEPRAZOLE : 40 MG) FILM COATED TABLETS,1516-148602-0391 - (CLARITHROMYCIN : 500 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

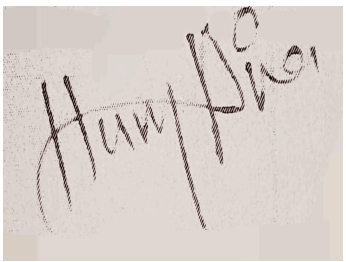
Stamp :

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

Patient 's signature{Parent if minor} :

Date : 05-Jun-2024

Signature :



Date : 05-Jun-2024