Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **ISHAN RAJEEWA PERUMADURA**	**Service Date**	**:12-Jun-2024**
Card No	: **I017-029-116125952-02**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	: **ISHAN RAJEEWA PERUMADURA**	**Doctor's Name**	**:Enomen Goodluck**
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	: **01-Oct-1991**		
Patient's Tel No	: **0529327188**		

Network : Green

Direct Access SP - YES

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 : Chest pain, and diffiulty breathing. Duration: 2days (10/06/2024) Also has feeling of chest tightness **Duration:**

Vitals: Temp : 37.2 Bp :120 Pulse :82 Resp :18

Clinical Findings:

Diagnosis: R07.9 - Chest pain, unspecified,R06.00 - Dyspnea, unspecified, **Date of Onset** :12/32/2024

Requested Investigations: 93000, ELECTROCARDIOGRAM COMPLETE,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,9, Consultation GP,94640, AIRWAY INHALATION TREATMENT,0006-402803-2071, VENTOLIN NEBULES,0188-135906-2441, PULMICORT **Estimated Cost** :

Prescriptions: **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.

Dr's Name : Enomen Goodluck **Stamp :**

Dr. Enomen Goodluck Ekata
General Practitioner
DHA No: 28040827-001
PESHAWAR MEDICAL CENTER LLC
DUBAI : U.A.E.

Signature : **Date** : 12-Jun-2024

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.

Patient 's signature{Parent if minor} : **Date :** 12-Jun-2024