

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name

: NISHANTHA INDUNIL JAYASINGHE ARACHCHILAGE

Card No

: I017-029-118687930-01

Policy Holder

: NISHANTHA INDUNIL JAYASINGHE ARACHCHILAGE

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

: 15-Feb-1976

Patient's Tel No

: 0567308860

Service Date

: 12-Jun-2024

Health Provider

: Irham Medical Center Arjan

Doctor's Name

: Enomen Goodluck

Co-Insurance

Network

: Green

Direct Access SP

: YES

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

: PC: Fever, headache, myalgia, nasal congestion, cough

Duration

:

Vitals

:Temp : 38.2 Bp :120 Pulse :82 Resp :18

Clinical Findings:

Diagnosis

: J06.9 - Acute upper respiratory infection, unspecified,R50.9 - Fever, unspecified,K29.00 - Acute gastritis without bleeding,R10.13 - Epigastric pain,

Date of Onset

: 12/09/2024

Requested Investigations

: 96365, THER/PROPH/DIAG IV INF INIT,0195-107704-0801, CEFTRIAXONE-TABUK IV,96372, THER/PROPH/DIAG INJ SC/IM,0005-149902-1021, CLOFEN ,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,0005-242802-0781, PANTONIX 40MG I.V.,0005-136504-1021, SCOPINAL,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,9, Consultation GP

Estimated Cost

:

Prescriptions

: 0005-116801-1161 - (SODIUM CITRATE : 57 MG/5ML) (AMMONIUM CHLORIDE : 131.5 MG/5 ML) (MENTHOL : 1.1 MG/5 ML) (DIPHENHYDRAMINE : 13.5 MG/5ML) SYRUP,0005-119803-1171 - (PREDNISOLONE : 20 MG) TABLETS,0252-185801-0391 - (DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS,0097-116207-0392 - (AMOXICILLIN : 500 MG) (CLAVULANIC ACID : 125 MG) FILM COATED TABLETS,1516-107902-1171 - (IBUPROFEN : 400 MG) TABLETS,0070-148701-1171 - (LORATADINE : 10 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

: Enomen Goodluck

Stamp

Signature

Date

: 12-Jun-2024

Patient 's signature{Parent : if minor}

Date

: Jun-2024