Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: NISHANTHA BANDARANAYAKA MUDIYANSELAGE**
Card No	**: I017-029-116122149-02**
Policy Holder	**: NISHANTHA BANDARANAYAKA MUDIYANSELAGE**
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	**: 22-Nov-1989**
Patient's Tel No	**: 0528867477**

Service Date **:15-Jun-2024** **Network** **:** Green

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

Doctor's Name **:Enomen Goodluck**

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 : Chest pain; Duration: last night (18hours prior to presentation). Pain is located to the left side of the chest, it is sharp and exercerbated on changing posture. There is no difficulty breathing, no cough and no palpitations. **Duration:**

Vitals: Temp : 36.3 Bp :120 Pulse :82 Resp :18

Clinical Findings:

Diagnosis: R07.9 - Chest pain, unspecified, **Date of Onset** : 15/46/2024

Estimated Cost :

Requested Investigations: 93000, ELECTROCARDIOGRAM COMPLETE,9, Consultation GP

Estimated Cost :

Prescriptions:

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 :**

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

Patient 's signature{Parent if minor} : **Date :** 15-Jun-2024

Signature : **Date** : 15-Jun-2024