

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

Health Provider

: Irham Medical Center Arjan

Doctor's Name

: Enomen Goodluck

Co-Insurance

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

Network

: Green

Direct Access SP

: YES

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 exercebated 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

Requested Investigations

: 93000, ELECTROCARDIOGRAM COMPLETE,9, Consultation GP

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.

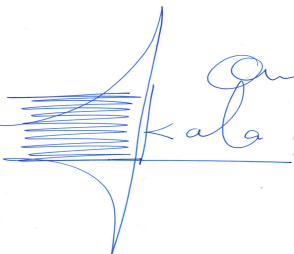
Dr's Name

: Enomen Goodluck

Stamp :

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

Signature :



Date : 15-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}



15-Jun-2024