Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **BUDDHINI MANODYA KUMARI KAHANDAWA KAHANDAWA MUDIYANSELAGE**	**Service Date**	**:22-Oct-2023**	**Network**	: Green
Card No	: **I017-029-119231692-01**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	: **BUDDHINI MANODYA KUMARI KAHANDAWA KAHANDAWA MUDIYANSELAGE**	**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	: **Female**				
Date Of Birth	: **24-Aug-1998**				
Patient's Tel No	: **0562383653**				

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 : High grade fever, cough, headache, weakness, pain in both ears with reduced hearing. Had previously presented 3 days ago and urinalysis showed bacteria in urine for which she was given ciprofloxacin and managed for UTI. She claims she is taking the medications as prescribed. **Duration:**

Vitals: Temp : 39 Bp :88 Pulse :110 Resp :22

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,H65.193 - Other acute nonsuppurative otitis media, bilateral,R05 - Cough,R50.9 - Fever, unspecified, **Date of Onset** :22/09/2023

Requested Investigations: 9.01, Follow Up Consultation GP,0005-149902-1021, CLOFEN ,96365, THER/PROPH/DIAG IV INF INIT,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,0195-107704-0801, CEFTRIAXONE-TABUK IV,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,, SICK LEAVE - 1 DHA **Estimated Cost** :

Prescriptions: 0696-107902-0392 - (IBUPROFEN : 400 MG) FILM COATED TABLETS,0252-185801-0391 - (DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS,0139-116206-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 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 :**

Dr. Enomen Goodluck Ekata
General Practitioner
DHA No: 20040827-001
PESHAWAR MEDICAL CENTER LLC
DUBAI : U.A.E.

Patient 's signature{Parent : if minor} **Date :** 22-Oct-2023

Signature : **Date** : 22-Oct-2023