

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name

: BUDDHINI MANODYA
KUMARI KAHANDAWA
KAHANDAWA
MUDIYANSELAGE

Card No

: I017-029-119231692-01

Policy Holder

: BUDDHINI MANODYA
KUMARI KAHANDAWA
KAHANDAWA
MUDIYANSELAGE

Payer Name

: ABU DHABI NATIONAL
INSURANCE COMPANY-ADNIC

TPA

: E CARE - Green Network

Validity

: 01-10-2023 To 30-09-2024

Gender

: Female

Date Of Birth

: 24-Aug-1998

Patient's Tel No

: 0562383653

Service Date

: 22-Oct-2023

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

: 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.

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,

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

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,

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.

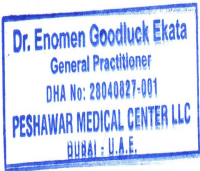
PATIENT'S DECLARATION :

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.

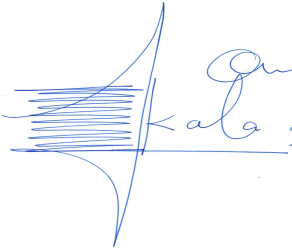
Dr's Name

: Enomen Goodluck

Stamp

:

Signature

:

Date

: 22-Oct-2023

Patient's signature{Parent : if minor}



Date

: 22-Oct-2023

https://irhamc.visionsoftw ares.ae/mr_ecare_claim_print.aspx?appld=42179&patId=46265

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