Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **ARAVINDA RUMESH NETHSARA ATHTHANAYAKE ATHTHANAYAKE MUDIYANSE**	**Service Date**	**:27-Oct-2023**
Card No	: **I017-029-116365659-02**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	: **ARAVINDA RUMESH NETHSARA ATHTHANAYAKE ATHTHANAYAKE MUDIYANSE**	**Doctor's Name**	**:Sajid Sanaullah**
Payer Name	: **ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **01-10-2023** To **30-09-2024**		
Gender	: **Male**		
Date Of Birth	: **01-Jan-1999**		
Patient's Tel No	: **561023776**		

Network : Green

Direct Access SP - YES

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 fever and severe chills and dry cough and vomiting since yesterday 26/10/2023 **Duration:**

Vitals: Temp : 36.7 Bp :110 Pulse :78 Resp :22

Clinical Findings:

Diagnosis: J02.9 - Acute pharyngitis, unspecified,R50.9 - Fever, unspecified,R05 - Cough,R11.2 - Nausea with vomiting, unspecified,J20.9 - Acute bronchitis, unspecified,K29.00 - Acute gastritis without bleeding, **Date of Onset** :27/22/2023

Requested Investigations: 2849-100143-0991, 5% W/V DEXTROSE 0.45% & W/V SODIUM CHLORIDE,0005-242802-0781, PANTONIX 40MG I.V.-(PANTOPRAZOLE (AS SODIUM) : 40 MG) POWDER FOR INFUSION,0248-122107-1021, DEXAMETHASONE SODIUM PHOSPHATE,0005-150403-1021, PREMOSAN ,0005-149902-1021, CLOFEN ,96360, HYDRATION IV INFUSION INIT,96374, THER/PROPH/DIAG INJ IV PUSH,94640, AIRWAY INHALATION TREATMENT,0188-135906-2441, PULMICORT,0006-124513-2071, VENTOLIN NEBULES,9, Consultation GP **Estimated Cost** :

Prescriptions: 0031-168201-0391 - (DOMPERIDONE : 10 MG) FILM COATED TABLETS,0006-402804-2481 - (SALBUTAMOL(AS SULPHATE) : 2 MG/5ML) SYRUP (SUGAR FREE),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 : Sajid Sanaullah **Stamp :**

Dr. Sajid Sanaullah Khan
General Practitioner
DHA No: 05758224-001
PESHAWAR MEDICAL CENTER LLC
DUBAI - U.A.E.

Patient 's signature{Parent : if minor}

Date : 27-Oct-2023

Signature :

Date : 27-Oct-2023