

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : CHANDAKA PRSANNA DE SILVA WALIMUNI
Card No : I017-029-118741777-01
Policy Holder : CHANDAKA PRSANNA DE SILVA WALIMUNI
Payer Name : ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC
TPA : E CARE - Green Network
Validity : 01-01-1900 To 30-09-2024
Gender : Male
Date Of Birth : 23-Nov-1984
Patient's Tel No : 0588312315

Service Date : 22-Nov-2023
Health Provider : Irham Medical Center Arjan
Doctor's Name : Sajid Sanaullah
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 : from 21/11/2023 has cough and sore throat Duration :		
Vitals: Temp : 36.1 Bp :124 Pulse :58 Resp :22		
Clinical Findings:		
Diagnosis: J02.9 - Acute pharyngitis, unspecified,R05 - Cough,R07.0 - Pain in throat,J03.91 - Acute recurrent tonsillitis, unspecified,		Date of Onset : 22/17/2023
Requested Investigations: 0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,0195-107704-0802, CEFTRIAXONE-TABUK IM,9, Consultation GP,96372, THER/PROPH/DIAG INJ SC/IM		Estimated Cost :
Prescriptions: 0139-116206-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS,0248-135501-1161 - (DEXTROMETHORPHAN : 125 MG/100ML) (DIPHENHYDRAMINE : 100 MG/100ML) (EPHEDRINE : 150 MG/100 ML) (GUAIFENESIN : 10 MG/ML) SYRUP,		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 : 	Patient's signature{Parent : if minor} 
Signature : 	Date : 22-Nov-2023	Date : 22-Nov-2023