

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : HIRUKA ANEDYA
IPITAKADUWA GAMAGE
Card No : I017-029-118969429-01
Policy Holder : HIRUKA ANEDYA
IPITAKADUWA GAMAGE

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 : 21-Apr-1991

Patient's Tel No : 97156583140

Service Date : 27-Nov-2023

Network : Green

Health Provider : Irham Medical Center Arjan

Direct Access SP - YES

Doctor's Name : Sajid Sanaullah

Co-Insurance :

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

Remarks :

☐ Acute ☐ Pre-existing and chronic ☐ Maternity

Chief Complaints : body pain and weakness from 20/11/2023 and sore throat Duration :

Vitals:Temp : 37.1 Bp :124 Pulse :100 Resp :22

Clinical Findings:

Diagnosis: J02.9 - Acute pharyngitis, unspecified,R53.1 - Weakness,J03.91 - Acute recurrent tonsillitis, unspecified, Date of Onset :27/56/2023

Requested Investigations: 0195-107704-0802, CEFTRIAXONE-TABUK IM,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,96372, THER/PROPH/DIAG INJ SC/IM,0006-124513-2071, VENTOLIN NEBULES,94640, AIRWAY INHALATION TREATMENT,9, Consultation GP Estimated : Cost

Prescriptions: 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}



27-
Date : Nov-2023

Signature :

Date : 27-Nov-2023