Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: DILAN SAMALKA SENANAYAKE KALUTARA KORALALAGE**
Card No	**: I017-029-117490343-02**
Policy Holder	**: DILAN SAMALKA SENANAYAKE KALUTARA KORALALAGE**
Payer Name	**: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**
TPA	**: E CARE - Green Network**
Validity	**: 01-10-2023** To **30-09-2024**
Gender	**: Male**
Date Of Birth	**: 18-Sep-1990**
Patient's Tel No	**: 0522946517**

Service Date	**:29-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

Remarks :

Network : Green

Direct Access SP - YES

☐ **Acute** ☐ **Pre-existing and chronic** ☐ **Maternity**

Chief Complaints : sore throat and cough from25/11/2023 , fever and body pain **Duration :**

Vitals: Temp : 37.4 Bp :125 Pulse :88 Resp :0

Clinical Findings:

Diagnosis: J02.9 - Acute pharyngitis, unspecified,J03.91 - Acute recurrent tonsillitis, unspecified,J20.9 - Acute bronchitis, unspecified, **Date of Onset** :29/43/2023

Requested Investigations: 0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,0006-124513-2071, VENTOLIN NEBULES,94640, AIRWAY INHALATION TREATMENT,0195-107704-0802, CEFTRIAXONE-TABUK IM-(CEFTRIAXONE : 1 G) POWDER FOR INJECTION,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP **Estimated Cost** :

Prescriptions: 0195-218701-1161 - (SODIUM CITRATE : N/A) (AMMONIUM CHLORIDE : N/A) (MENTHOL : N/A) (DEXTROMETHORPHAN : N/A) (DIPHENHYDRAMINE : N/A) (PSEUDOEPHEDRINE : N/A) 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} :

Date : 29-Nov-2023

Signature :

Date : 29-Nov-2023