Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **DUMINDA SANJAYA NAKANDALAGE DON**	**Service Date**	**:01-Dec-2023**
Card No	: **I017-029-117303312-02**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	: **DUMINDA SANJAYA NAKANDALAGE DON**	**Doctor's Name**	**:Enomen Goodluck**
Payer Name	: **ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:
TPA	: **E CARE - Green Network**	**Remarks**	:
Validity	: **01-01-1900** To **30-09-2024**		
Gender	: **Male**		
Date Of Birth	: **08-Sep-1979**		
Patient's Tel No	: **0569042585**		

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 : C/o: Generalized body pain, cough, chest pain and wheezing since the last 4days. Had initially presented to this facility but has not improved. Cough is productive of dark brown sputum. Also has anorexia. Influenza testing is strongly adviced.

Duration:

Vitals: Temp : 37.7 Bp :125 Pulse :95 Resp :19

Clinical Findings:

Diagnosis: J22 - Unspecified acute lower respiratory infection,J45.21 - Mild intermittent asthma with (acute) exacerbation,J20.9 - Acute bronchitis, unspecified,

Date of Onset :01/32/2023

Requested Investigations: Influenza A & B, Influenza A & B,94640, AIRWAY INHALATION TREATMENT,0006-124513-2071, VENTOLIN NEBULES,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,96365, THER/PROPH/DIAG IV INF INIT,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,0195-107704-0801, CEFTRIAXONE-TABUK IV,9.01, Follow Up Consultation GP

Estimated Cost :

Prescriptions: 0005-119803-1172 - (PREDNISOLONE : 20 MG) TABLETS,

Estimated Cost :

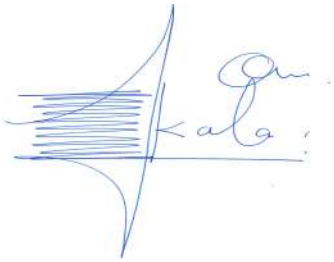
MEDICAL PRACTITIONER DECLARATION :

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.

Dr's Name : Enomen Goodluck

Stamp :

Signature :



Date : 01-Dec-2023

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.

Patient 's signature{Parent if minor} :

Date : 01-Dec-2023