Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **ACHINI IMALKA PEIRIS KALUTHANTHRIGE**	**Service Date**	**:01-Dec-2023**
Card No	: **I017-029-118741775-01**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	: **ACHINI IMALKA PEIRIS KALUTHANTHRIGE**	**Doctor's Name**	**:Enomen Goodluck**
Payer Name	: **ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:
TPA	: **E CARE - Green Network**	**Remarks**	:
Validity	: **01-10-2023** To **30-09-2024**		
Gender	: **Female**		
Date Of Birth	: **16-Jun-1996**		
Patient's Tel No	: **0557107432**		

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: Cough, fever and generalized body pains. Cough is dry. Symptom onset since 3days. **Duration:**

Vitals: Temp : 38.5 Bp :95 Pulse :124 Resp :19

Clinical Findings:

Diagnosis: J00 - Acute nasopharyngitis [common cold],J02.9 - Acute pharyngitis, unspecified,J22 - Unspecified acute lower respiratory infection, **Date of Onset** :01/44/2023

Requested Investigations: 9, Consultation GP,96365, THER/PROPH/DIAG IV INF INIT,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,0005-149902-1021, CLOFEN ,96372, THER/PROPH/DIAG INJ SC/IM,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,0195-107704-0801, CEFTRIAXONE-TABUK IV,96374, THER/PROPH/DIAG INJ IV PUSH **Estimated Cost** :

Prescriptions: 0027-128802-2021 - (XYLOMETAZOLINE HYDROCHLORIDE : 0.1%) NASAL DROPS,0195-148602-0391 - (CLARITHROMYCIN : 500 MG) FILM COATED TABLETS,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,0027-265802-1161 - (BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V) SYRUP,0696-107902-0392 - (IBUPROFEN : 400 MG) FILM COATED TABLETS,0252-185801-0391 - (DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED 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.

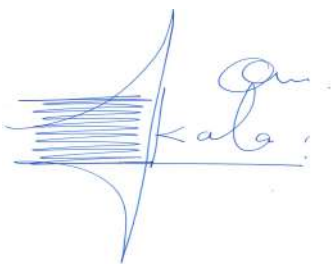
Dr's Name : Enomen Goodluck

Stamp :

Patient 's signature{Parent if minor} :

Date : 01-Dec-2023

Signature :



Date : 01-Dec-2023