

Administrative**MEDICAL CLAIM FORM****Claim Ref:**

Patient Name : LAKJAYA WARNAJITH
Card No : I017-029-116122331-02
Policy Holder : LAKJAYA WARNAJITH
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 : 30-Sep-1990
Patient's Tel No : 0563007824

Service Date : 13-Dec-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 : Severe pharyngitis and sore throat caused by CMV started 10/12/2023 Duration :		
Vitals: Temp : 37.6 Bp :125 Pulse :92 Resp :22		
Clinical Findings:		
Diagnosis: B27.10 - Cytomegaloviral mononucleosis without complications,J02.8 - Acute pharyngitis due to other specified organisms,R19.7 - Diarrhea, unspecified,		Date of Onset : 13/46/2023
Requested Investigations: 9.01, Follow Up Consultation GP,0102-100104-1001, SODIUM CHLORIDE & DEXTROSE B.P.,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,0195-107704-0801, CEFTRIAXONE-TABUK IV,0005-149902-1021, CLOFEN ,96360, HYDRATION IV INFUSION INIT,96374, THER/PROPH/DIAG INJ IV PUSH,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,85651, SEDIMENTATION RATE RBC NON AUTOMATED,86140, C REACTIVE PROTEIN,86644, ANTIBODY CYTOMEGALOVIRUS CMV		Estimated Cost :
Prescriptions: 0699-200001-1451 - (LOPERAMIDE : 2 MG) CAPSULES (HARD GELATIN),6616-230505-0832 - (SODIUM CHLORIDE : 2.6 G) (POTASSIUM CHLORIDE : 1.5 G) (SODIUM CITRATE : 2.9 G) (DEXTROSE ANHYDROUS : 13.5 G) POWDER FOR SOLUTION,		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

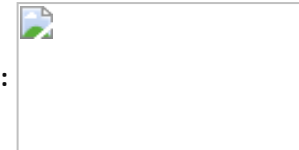
regarding my medical condition & history for purpose of
determining insurance benefits.

**Dr's
Name** : Sajid Sanaullah

Stamp :



**Patient 's
signature{Parent :
if minor}**



Date : 13-
Dec-
2023

Signature :



Date : 13-Dec-2023