Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **LAKJAYA WARNAJITH SANJEEWA SAMARATHUNGA**	**Service Date**	**:13-Dec-2023**	**Network**	: Green
Card No	: **I017-029-116122331-02**	**Health Provider**	**:Irham Medical Center Arjan**	**Direct Access SP - YES**	
Policy Holder	: **LAKJAYA WARNAJITH SANJEEWA SAMARATHUNGA**	**Doctor's Name**	**:Sajid Sanaullah**		
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	: **30-Sep-1990**				
Patient's Tel No	: **0563007824**				

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 : 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 :

Dr. Sajid Sanaullah Khan
General Practitioner
DHA No: 05758224-001
PESHAWAR MEDICAL CENTER LLC
DUBAI - U.A.E.

Patient 's signature{Parent : if minor}

Date : 13-Dec-2023

Signature :

Date : 13-Dec-2023