

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 : 14-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 EXUDATE IN PHARYNX AND HIGH LEUKOCYTOSIS
 AND HIGH CRP AND ESR DONE IN 13/12/2023

Vitals:

Clinical Findings:

Diagnosis: J02.8 - Acute pharyngitis due to other specified organisms, R07.0 - Pain in throat, J02.0 - Streptococcal pharyngitis, R50.9 - Fever, unspecified, R13.13 - Dysphagia, pharyngeal phase,

Date of Onset : 14/11/2023

Requested Investigations: 9.01, Follow Up Consultation GP, 0195-107704-0802, CEFTRIAXONE-TABUK IM, 0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE, 0005-149902-1021, CLOFEN, 96365, THER/PROPH/DIAG IV INF INIT, 96374, THER/PROPH/DIAG INJ IV PUSH, 0195-107704-0801, CEFTRIAXONE-TABUK IV, 96360, HYDRATION IV INFUSION INIT, 0102-100104-1001, SODIUM CHLORIDE & DEXTROSE B.P.

Estimated Cost :

Prescriptions:

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 :

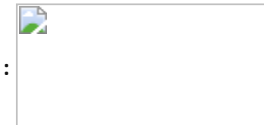
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Sajid Sanaullah

Stamp :



Patient's signature {Parent if minor} :



Date : 14-Dec-2023

Signature :

Date : 14-Dec-2023