

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 : 15-Dec-2023
Health Provider : Irham Medical Center Arjan
Doctor's Name : Sajid Sanaullah

Network : Green
Direct Access SP - YES

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

Co-Insurance :

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: Temp : 37.6 Bp :125 Pulse :92 Resp :22

Clinical Findings:

Diagnosis: R13.13 - Dysphagia, pharyngeal phase, J02.8 - Acute pharyngitis due to other specified organisms, A60.9 - Anogenital herpesviral infection, unspecified, B37.9 - Candidiasis, unspecified,

Date of Onset : 15/21/2023

Requested Investigations: 9.01, Follow Up Consultation GP, 0102-100104-1001, SODIUM CHLORIDE & DEXTROSE B.P., 96360, HYDRATION IV INFUSION INIT, 96374, THER/PROPH/DIAG INJ IV PUSH, 0005-149902-1021, CLOFEN, 0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE, 0195-107704-0802, CEFTRIAXONE-TABUK IM, 0005-111805-1021, CHLOROHISTOL 10MG-(CHLORPHENIRAMINE MALEATE : 10 MG/ML) SOLUTION FOR INJECTION, 96372, THER/PROPH/DIAG INJ SC/IM, 0195-107704-0802, CEFTRIAXONE-TABUK IM

Estimated Cost :

Prescriptions: 0067-116704-1161 - (DIPHENHYDRAMINE : 7MG/5ML) SYRUP, 0005-222102-1111 - (NYSTATIN : 100000 IU/ML) SUSPENSION,

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 :

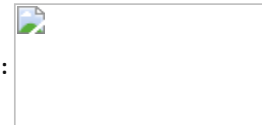
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Sajid Sanaullah

Stamp :



Patient's signature {Parent : if minor}



Date : 15-Dec-2023

Signature :

Date : 15-Dec-2023