Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **LAKJAYA WARNAJITH SANJEEWA SAMARATHUNGA**	**Service Date**	**:15-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 EXUDATE IN PHARYNX AND HIGH LEUKOCYTOSIS AND HIGH CRP AND ESR DONE IN 13/12/2023 **Duration:**

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