Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: LAKJAYA WARNAJITH SANJEEWA SAMARATHUNGA**	**Service Date**	**:16-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 : **Duration :**

Vitals:

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** **:**16/30/2023

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

Prescriptions: **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 : 16-Dec-2023

Signature :

Date : 16-Dec-2023