Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **LAKJAYA WARNAJITH SANJEEWA SAMARATHUNGA**	**Service Date**	**:17-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 : 36.7 Bp :130 Pulse :100 Resp :21

Clinical Findings:

Diagnosis: J02.8 - Acute pharyngitis due to other specified organisms,J03.90 - Acute tonsillitis, unspecified,H66.003 - Acute suppr otitis media w/o spon rupt ear drum, bilateral, **Date of Onset** :17/58/2023

Requested Investigations: 0195-107704-0802, CEFTRIAXONE-TABUK IM,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,0005-149902-1021, CLOFEN ,96372, THER/PROPH/DIAG INJ SC/IM,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,85651, SEDIMENTATION RATE RBC NON AUTOMATED,86644, ANTIBODY CYTOMEGALOVIRUS CMV,9.01, Follow Up Consultation GP **Estimated Cost** :

Prescriptions: 0219-142902-1452 - (CEFIXIME : 400 MG) CAPSULES (HARD GELATIN),0067-116705-1161 - (DIPHENHYDRAMINE : 14 MG/5 ML) SYRUP, **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 : 17-Dec-2023

Signature :

Date : 17-Dec-2023