Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: INDIKA PRASAD RANASINGHA PERAKOTUWE WEDARALLAGE**	**Service Date**	**:23-Dec-2023**
Card No	**: I017-029-116122251-02**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	**: INDIKA PRASAD RANASINGHA PERAKOTUWE WEDARALLAGE**	**Doctor's Name**	**:Sajid Sanaullah**
Payer Name	**: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:
TPA	**: E CARE - Green Network**	**Remarks**	:
Validity	**: 01-10-2023** To **30-09-2024**		
Gender	**: Male**		
Date Of Birth	**: 01-Jan-1983**		
Patient's Tel No	**: 524933547**		

Network : Green

Direct Access SP - YES

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 : ACUTE SINUSITIS, dry and wet cough, all muscular pain, HEADACHE IN FRONT OF THE HEAD AFTER VIRAL INFECTION, FEVER WITH CHILLS **Duration:**

Vitals: Temp : 36.8 Bp :119 Pulse :87 Resp :22

Clinical Findings:

Diagnosis: R50.81 - Fever presenting with conditions classified elsewhere,M79.10 - Myalgia, unspecified site,R05 - Cough,R07.0 - Pain in throat, **Date of Onset** :23/32/2023

Requested Investigations: 0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,0102-100104-1001, SODIUM CHLORIDE & DEXTROSE B.P.-(SODIUM CHLORIDE : 0.9%) (DEXTROSE : 5%) SOLUTION FOR INFUSION,0005-111805-1021, CHLOROHISTOL 10MG-(CHLORPHENIRAMINE MALEATE : 10 MG/ML) SOLUTION FOR INJECTION,0195-107704-0802, CEFTRIAXONE-TABUK IM,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,96372, THER/PROPH/DIAG INJ SC/IM,96365, THER/PROPH/DIAG IV INF INIT,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,84545, UREA NITROGEN CLEARANCE,86140, C REACTIVE PROTEIN,85652, SEDIMENTATION RATE RBC AUTOMATED,96360, HYDRATION IV INFUSION INIT,96374, THER/PROPH/DIAG INJ IV PUSH,9, Consultation GP,96365, THER/PROPH/DIAG IV INF INIT **Estimated Cost** :

Prescriptions: 0046-123701-0392 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,2027-560101-0391 - (IBUPROFEN : 150 MG) (PARACETAMOL : 500 MG) FILM COATED TABLETS,1144-253101-1162 - (HEDERA HELIX (IVY) : 7MG/ML) SYRUP,0139-116207-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 500 MG) TABLETS, **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 : 23-Dec-2023

Signature :  **Date :** 23-Dec-2023