

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : LAKJAYA WARNAJITH
SANJEEWA SAMARATHUNGA
Card No : I017-029-116122331-02
Policy Holder : LAKJAYA WARNAJITH
SANJEEWA SAMARATHUNGA
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 : 03-Feb-2024
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

Remarks :

☐ Acute	☐ Pre-existing and chronic	☐ Maternity
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Chief Complaints : C/o: Pain in throat, running nose and nasal congestion and slight cough. Duration: Onset since 2 days.

Vitals: Temp : 36.8 Bp :122 Pulse :88 Resp :20

Clinical Findings:

Diagnosis: J02.8 - Acute pharyngitis due to other specified organisms, J00 - Acute nasopharyngitis [common cold], Date of Onset: 03/29/2024

Requested Investigations: 9, Consultation GP

Estimated Cost :

Prescriptions: 0005-119803-1171 - (PREDNISOLONE : 20 MG) TABLETS, 0696-148701-1172 - (LORATADINE : 10 MG) TABLETS, 2027-560101-0392 - (IBUPROFEN : 150 MG) (PARACETAMOL : 500 MG) FILM COATED TABLETS, 0252-185801-0391 - (DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED 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.
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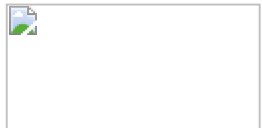
Dr's Name : Sajid Sanaullah

Stamp : 

Signature : 

Date : 03-Feb-2024

Patient's signature {Parent : if minor}



Date : Feb-2024