Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **ISHAN UMANGA JAYASINGHE JAYASINGHE MUDIYANSELAGE**	**Service Date**	**:10-Feb-2024**	**Network**	**:** Green
Card No	: **I017-029-119209532-01**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	: **ISHAN UMANGA JAYASINGHE JAYASINGHE MUDIYANSELAGE**	**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	: **20-Jun-1995**				
Patient's Tel No	: **0504572187**				

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 : C/o: Cough productive of thick yellow mucus, difficulty breathing, fever and chest pain. He is a known asthmatic. but not hypertensive and not diabetic. Has also blocked nostrils. **Duration:**

Vitals: Temp : 36.7 Bp :106 Pulse :74 Resp :22

Clinical Findings:

Diagnosis: J45.41 - Moderate persistent asthma with (acute) exacerbation,J22 - Unspecified acute lower respiratory infection,J30.9 - Allergic rhinitis, unspecified,R05 - Cough, **Date of Onset** :10/09/2024

Requested Investigations: 94640, AIRWAY INHALATION TREATMENT,0188-135906-2441, PULMICORT,0006-402803-2071, VENTOLIN NEBULES,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,0195-107704-0801, CEFTRIAXONE-TABUK IV,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,2190-106618-1001, PARAFUSIV,96365, THER/PROPH/DIAG IV INF INIT,96374, THER/PROPH/DIAG INJ IV PUSH,9, Consultation GP **Estimated Cost :**

Prescriptions: 0005-124508-1173 - (SALBUTAMOL : 2 MG) TABLETS,1204-571401-1161 - (GUAIFENESIN : 100 MG/5ML) (PSEUDOEPHEDRINE HCL : 30 MG/5ML) (TRIPROLIDINE HCL : 1.25 MG/5ML) SYRUP,0139-116206-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS,0005-119803-1171 - (PREDNISOLONE : 20 MG) TABLETS,0090-265901-1171 - (MONTELUKAST : 10 MG) TABLETS,0205-290301-0391 - (LEVOCETIRIZINE (DIHCL OR HCL) : 5 MG) FILM COATED TABLETS,5253-649501-3851 - (MOMETASONE FUROATE (AS MONOHYDRATE) : 50 MCG/DOSE) NASAL SPRAY, **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 : 10-Feb-2024

Signature :

Date : 10-Feb-2024