Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **HIRUSHA BATHIYA RATNAYAKA**	**Service Date**	**:10-Feb-2024**
Card No	: **I017-029-119293725-01**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	: **HIRUSHA BATHIYA RATNAYAKA**	**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	: **03-Dec-2001**		
Patient's Tel No	: **971566442706**		

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 : C/o: Dry cough, with associated chest pain, Symptom onset since yesterday. **Duration:**

Vitals: Temp : 36.9 Bp :123 Pulse :86 Resp :22

Clinical Findings:

Diagnosis: J20.9 - Acute bronchitis, unspecified,J22 - Unspecified acute lower respiratory infection,J06.0 - Acute laryngopharyngitis,J30.9 - Allergic rhinitis, unspecified, **Date of Onset** :10/56/2024

Requested Investigations: 94640, AIRWAY INHALATION TREATMENT,0006-402803-2071, VENTOLIN NEBULES,0188-135906-2441, PULMICORT,9, Consultation GP **Estimated Cost** :

Prescriptions: 5253-649501-3851 - (MOMETASONE FUROATE (AS MONOHYDRATE) : 50 MCG/DOSE) NASAL SPRAY,1204-571401-1161 - (GUAIFENESIN : 100 MG/5ML) (PSEUDOEPHEDRINE HCL : 30 MG/5ML) (TRIPROLIDINE HCL : 1.25 MG/5ML) SYRUP,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED 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.

Dr's Name : Sajid Sanaullah

Stamp :

Patient 's signature{Parent : if minor}

Date : 10-Feb-2024

Signature :

Date : 10-Feb-2024