

Administrative

Patient Name

:

HIRUSHA BATHIYA RATNAYAKA

Card No

:

I017-029-119293725-01

Policy Holder

:

HIRUSHA BATHIYA RATNAYAKA

Payer Name

:

ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC

TPA

:

E CARE - Green Network

Validity

:

01-10-2023 To 30-09-2024

Gender

:

Male

Date Of Birth

:

03-Dec-2001

Patient's Tel No

:

971566442706

Service Date

:

10-Feb-2024

Health Provider

:

Irham Medical Center Arjan

Doctor's Name

:

Sajid Sanaullah

Co-Insurance

:

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

Network

:

Green

Direct Access SP - YES

Remarks

:

☐ 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.

Dr's Name

:

Sajid Sanaullah

Stamp :

Dr. Sajid Sanaullah Khan

General Practitioner

DHA No: 05758224-001

PESHAWAR MEDICAL CENTER LLC

DUBAI - U.A.E.

Signature :



Date

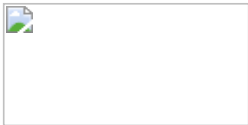
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10-Feb-2024

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.

Patient 's signature{Parent : if minor}



Date

:

10-Feb-2024

https://irhamc.visionsoftwares.ae/mr_ecare_claim_print.aspx?appld=46104&patld=51784

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