Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **MANISHA ANJALI SENANAYAKA GAMAGE**	**Service Date**	**:19-Feb-2024**
Card No	: **I017-029-118993192-01**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	: **MANISHA ANJALI SENANAYAKA GAMAGE**	**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	: **Female**		
Date Of Birth	: **01-Sep-1997**		
Patient's Tel No	: **0525455742**		

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 HEAVY PV BLEEDING SINCE 2 MONTHD ,4-5 PADS PER DAY NO KNOWN MEDICINE ALLERGY **Duration:**

Vitals: Temp : 36.7 Bp :111 Pulse :78 Resp :22

Clinical Findings:

Diagnosis: N93.9 - Abnormal uterine and vaginal bleeding, unspecified, **Date of Onset** :19/39/2024

Requested Investigations: 9, Consultation GP,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,85651, SEDIMENTATION RATE RBC NON AUTOMATED,85610, PROTHROMBIN TIME,85730, THROMBOPLASTIN TIME PARTIAL PLASMA/WHOLE BLOOD **Estimated Cost** :

Prescriptions: **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 : 19-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 : 19-Feb-2024