Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: NISHANTHA BANDARANAYAKA MUDIYANSELAGE**
Card No	**: I017-029-116122149-02**
Policy Holder	**: NISHANTHA BANDARANAYAKA MUDIYANSELAGE**
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	**: 22-Nov-1989**
Patient's Tel No	**: 0528867477**

Service Date **:20-Feb-2024** **Network** : Green

Health Provider **:Irham Medical Center Arjan** **Direct Access SP - YES**

Doctor's Name **:Sajid Sanaullah**

Co-Insurance :

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

Remarks :

☐ **Acute** ☐ **Pre-existing and chronic** ☐ **Maternity**

Chief Complaints : For follow up Rectal bleeding has stopped. Still has anal pain, severe after defecation. **Duration:**

Vitals: Temp : 36.7 Bp :124 Pulse :78 Resp :18

Clinical Findings:

Diagnosis: K64.1 - Second degree hemorrhoids,K62.5 - Hemorrhage of anus and rectum,K60.2 - Anal fissure, unspecified, **Date of Onset** :20/43/2024

Requested Investigations: 9, Consultation GP **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.

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 :**

Dr. Sajid Sanaullah Khan
General Practitioner
DHA No: 05758224-001
PESHAWAR MEDICAL CENTER LLC
DUBAI - U.A.E.

Patient 's signature{Parent : if minor} **Date :** 20-Feb-2024

Signature :  **Date** : 20-Feb-2024