

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 : 06-Mar-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 : f/u hemorrhoids pain is still present but no rectal bleeding **Duration** :

Vitals: Temp : 36.5 Bp :128 Pulse :72 Resp :22

Clinical Findings:

Diagnosis: K64.9 - Unspecified hemorrhoids, K62.89 - Other specified diseases of anus and rectum, **Date of Onset** : 06/00/2024

Requested Investigations: 9, Consultation GP **Estimated Cost** :

Prescriptions: 0005-101701-0391 - (ACECLOFENAC : 100 MG) FILM COATED TABLETS, 0277-169202-
 2221 - (LIDOCAINE : 2%) (CALCIUM DOBESILATE : 4%) RECTAL OINTMENT, 6602-938601-0551 - (FIBER : Cost
 3 G / 10 ML) (LACTITOL : 2.5 G / 10 ML) LIQUID,

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 :

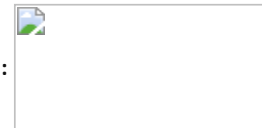
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Sajid Sanaullah

Stamp :



Patient's signature {Parent :
 if minor}



06-
Date : Mar-
 2024

Signature :

Date : 06-Mar-2024