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

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0005-101701-0391 - (ACECLOFENAC : 100 MG) FILM COATED TABLETS,0277-169202-2221 - (LIDOCAINE : 2%) (CALCIUM DOBESILATE : 4%) RECTAL OINTMENT,6602-938601-0551 - (FIBER : 3 G / 10 ML) (LACTITOL : 2.5 G / 10 ML) LIQUID, **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 : 06-Mar-2024

Signature :

Date : 06-Mar-2024