Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **KASUN CHATHURANGA PULUKKUTTI ARACHCHIGE DON**	**Service Date**	**:07-Mar-2024**
Card No	: **I017-029-120111933-01**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	: **KASUN CHATHURANGA PULUKKUTTI ARACHCHIGE DON**	**Doctor's Name**	**:Sajid Sanaullah**
Payer Name	: **ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:
TPA	: **E CARE - Green Network**	**Remarks**	:
Validity	: **21-11-2023** To **30-09-2024**		
Gender	: **Male**		
Date Of Birth	: **17-Mar-1998**		
Patient's Tel No	: **0509453649**		

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 multiple red and itchy bumps on chest ,back and face on assesment the pattern of rashes and bumps is suggestive of chicken pox **Duration:**

Vitals: Temp : 37.9 Bp :109 Pulse :74 Resp :22

Clinical Findings:

Diagnosis: L50.9 - Urticaria, unspecified,R50.9 - Fever, unspecified,R52 - Pain, unspecified,R05 - Cough,E86.0 - Dehydration, **Date of Onset** :07/46/2024

Requested Investigations: 2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,0005-111805-1021, CHLOROHISTOL 10MG-(CHLORPHENIRAMINE MALEATE : 10 MG/ML) SOLUTION FOR INJECTION,96374, THER/PROPH/DIAG INJ IV PUSH,0102-100104-1001, SODIUM CHLORIDE & DEXTROSE B.P.,96360, HYDRATION IV INFUSION INIT,9, Consultation GP **Estimated Cost** :

Prescriptions: 2027-560101-0391 - (IBUPROFEN : 150 MG) (PARACETAMOL : 500 MG) FILM COATED TABLETS,0005-116801-1161 - (SODIUM CITRATE : 57 MG/5ML) (AMMONIUM CHLORIDE : 131.5 MG/5 ML) (MENTHOL : 1.1 MG/5 ML) (DIPHENHYDRAMINE : 13.5 MG/5ML) SYRUP,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,0006-106601-0392 - (PARACETAMOL : 500 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.

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 : 07-Mar-2024

Signature : 

Date : 07-Mar-2024