

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : KULESHIKA OMALI PUSSALLA

Card No : I017-029-116125788-01

Policy Holder : KULESHIKA OMALI PUSSALLA

Payer Name : ABU DHABI NATIONAL
INSURANCE COMPANY-ADNIC

TPA : E CARE - Green Network

Validity : 01-10-2023 To 30-09-2024

Gender : Female

Date Of Birth : 09-Dec-1984

Patient's Tel No : 0588975114

Service Date :15-Mar-2024

Network : Green

Health Provider :Irham Medical Center Arjan

Direct Access SP - YES

Doctor's Name :Maimoona

Co-Insurance :

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

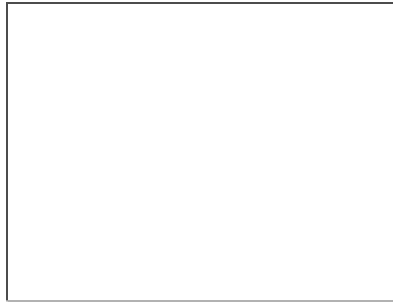
Remarks :

☐ Acute	☐ Pre-existing and chronic	☐ Maternity
Chief Complaints : c/o flu,headache ,fever since 2 days		
Duration :		
Vitals:Temp : 37.6 Bp :129 Pulse :92 Resp :22		
Clinical Findings:		
Diagnosis: J00 - Acute nasopharyngitis [common cold],R05 - Cough,R52 - Pain, unspecified,J06.9 - Acute upper respiratory infection, unspecified,		Date of Onset :15/34/2024
Estimated Cost :		
Requested Investigations: 9, Consultation GP		
Prescriptions: 0027-142201-0831 - (DICLOFENAC POTASSIUM : 50 MG) POWDER FOR SOLUTION, 0006-106601-0392 - (PARACETAMOL : 500 MG) FILM COATED TABLETS,0005-119805-1172 - (PREDNISOLONE : 5 MG) TABLETS,1144-253101-1162 - (HEDERA HELIX (IVY) : 7MG/ML) SYRUP, 0252-185801-0391 - (DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 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

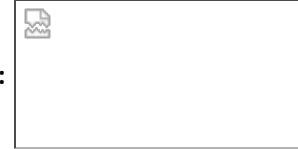
insurance benefits.

**Dr's
Name** : Maimoona

Stamp :



**Patient 's
signature{Parent :
if minor}**



Date : 15-
Mar-2024

Signature :



Date : 15-Mar-2024