

Administrative

Patient Name

: ISHAN RAJEEWA PERUMADURA

Card No

: I017-029-116125952-02

Policy Holder

: ISHAN RAJEEWA PERUMADURA

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

: 01-Oct-1991

Patient's Tel No

: 0529327188

Service Date

: 11-Apr-2024

Health Provider

: Irham Medical Center Arjan

Doctor's Name

: Enomen Goodluck

Co-Insurance

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

Network

: Green

Direct Access SP

: YES

Claim Ref:

☐ Acute

☐ Pre-existing and chronic

☐ Maternity

Chief Complaints

: Cough, pain in throat and fever. also has chest pain when coughing. Cough is productive of clear sputum that is difficult to expectorate.

Duration:

Vitals

:Temp : 37 Bp :108 Pulse :74 Resp :18

Clinical Findings:

Diagnosis

: J22 - Unspecified acute lower respiratory infection,J02.8 - Acute pharyngitis due to other specified organisms,R05 - Cough,

Date of Onset

:11/32/2024

Requested Investigations

: 9, Consultation GP

Estimated Cost

:

Prescriptions

: 0252-185801-0391 - (DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS,1204-571401-1161 - (GUAIFENESIN : 100 MG/5ML) (PSEUDOEPHEDRINE HCL : 30 MG/5ML) (TRIPROLIDINE HCL : 1.25 MG/5ML) SYRUP,0005-119803-1171 - (PREDNISOLONE : 20 MG) TABLETS,0139-116206-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) 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.

Dr's Name

: Enomen Goodluck

Stamp

Dr. Enomen Goodluck Ekata

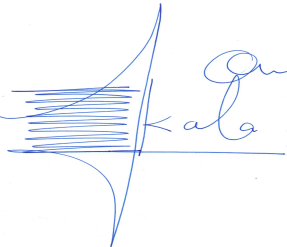
General Practitioner

DHA No: 28040827-001

PESHAWAR MEDICAL CENTER LLC

DUBAI - U.A.E.

Signature



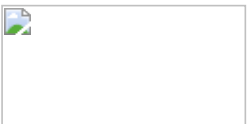
Date

: 11-Apr-2024

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.

Patient 's signature{Parent : if minor}



Date

: 11-Apr-2024