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	:23-Apr-2024
Health Provider	:Irham Medical Center Arjan
Doctor's Name	:Enomen Goodluck
Co-Insurance	:

Network : Green

Direct Access SP - YES

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 : Purulent discharge from the left ear, but no pain. it is sometimes itchy. ENT: **Duration:**
Discharge seen in the ear canal with hyperemia.

Vitals: Temp : 37 Bp :124 Pulse :89 Resp :18

Clinical Findings:

Diagnosis: H65.06 - Acute serous otitis media, recurrent, bilateral,H60.8X3 - Other otitis externa, bilateral,E78.49 - Other hyperlipidemia,Z83.3 - Family history of diabetes mellitus,J30.9 - Allergic rhinitis, unspecified, **Date of Onset** :23/50/2024

Requested Investigations: 82947, GLUCOSE,82947, GLUCOSE QUANTITATIVE BLOOD XCPT REAGENT STRIP,80061, LIPID PANEL,9, Consultation GP **Estimated Cost** :

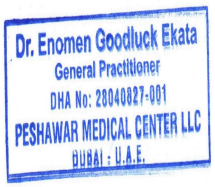
Prescriptions: 0005-119803-1171 - (PREDNISOLONE : 20 MG) TABLETS,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,6894-822002-1681 - (DEXAMETHASONE SODIUM PHOSPHATE : 1MG/ML) (GENTAMICIN SULPHATE : 3 MG/ML) EYE / EAR DROPS,0219-142902-1451 - (CEFIXIME : 400 MG) CAPSULES (HARD GELATIN), **Estimated Cost** :

MEDICAL PRACTITIONER DECLARATION :

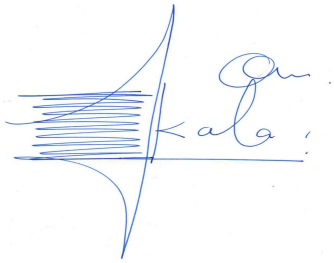
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

Dr's Name : Enomen Goodluck

Stamp :



Signature :



Date : 23-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 : 23-Apr-2024