Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: Dhanushka Piyumal silva**	**Service Date**	**:29-Apr-2024**
Card No	**: I017-029-119973354-01**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	**: Dhanushka Piyumal silva**	**Doctor's Name**	**:Enomen Goodluck**
Payer Name	**: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:
TPA	**: E CARE - Green Network**	**Remarks**	:
Validity	**: 01-10-2023** To **30-09-2024**		
Gender	**: Male**		
Date Of Birth	**: 04-Nov-1999**		
Patient's Tel No	**: 971501436913**		

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: Pain in throat for the past 3days, and cough Also has blisters in the mouth since yesterday **Duration:**

Vitals: Temp : 36.3 Bp :98 Pulse :76 Resp :22

Clinical Findings:

Diagnosis: J02.9 - Acute pharyngitis, unspecified,J30.9 - Allergic rhinitis, unspecified,R07.0 - Pain in throat, **Date of Onset :**29/02/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

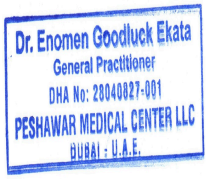
Prescriptions: 0027-265802-1161 - (BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V) SYRUP,0097-127405-0392 - (AZITHROMYCIN : 500 MG) FILM COATED TABLETS,2027-560101-0392 - (IBUPROFEN : 150 MG) (PARACETAMOL : 500 MG) FILM COATED TABLETS,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,0252-185801-0391 - (DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS, **Estimated Cost :**

MEDICAL PRACTITIONER DECLARATION :

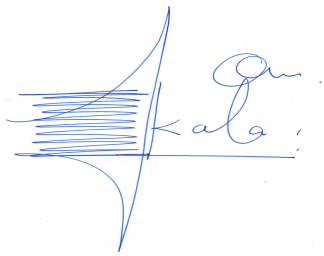
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

Dr's Name : Enomen Goodluck

Stamp :



Signature :



Date : 29-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 : 29-Apr-2024