Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **ACHINI IMALKA PEIRIS KALUTHANTHRIGE**	**Service Date**	**:30-Apr-2024**
Card No	: **I017-029-118741775-01**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	: **ACHINI IMALKA PEIRIS KALUTHANTHRIGE**	**Doctor's Name**	**:Humaira**
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	: **Female**		
Date Of Birth	: **16-Jun-1996**		
Patient's Tel No	: **0557107432**		

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 : co sneezing nasal blockage 1 day bady ache oe dry cough chest is clear no added sounds vitals are stable **Duration:**

Vitals: Temp : 37.3 Bp :96 Pulse :98 Resp :22

Clinical Findings:

Diagnosis: J30.9 - Allergic rhinitis, unspecified,R52 - Pain, unspecified,R09.81 - Nasal congestion,R05 - Cough, **Date of Onset :**30/44/2024

Requested Investigations: 9, Consultation GP,0006-402803-2071, VENTOLIN NEBULES-(SALBUTAMOL : 5 MG/2.5ML) NEBULIZING SOLUTION,94640, AIRWAY INHALATION TREATMENT **Estimated Cost** :

Prescriptions: 0097-393801-2471 - (AMMONIUM CHLORIDE : 131.5 MG/5 ML) (DIPHENHYDRAMINE HCL : 13.5 MG/5ML) SYRUP (ALCOHOL FREE),0005-107001-0052 - (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED 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.

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 : Humaira **Stamp :** **Patient 's signature{Parent if minor}** : **Date :** 30-Apr-2024

Signature : **Date** : 30-Apr-2024