

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : LAKJAYA WARNAJITH
Card No : I017-029-116122331-02
Policy Holder : LAKJAYA WARNAJITH
Payer Name : ABU DHABI NATIONAL
INSURANCE COMPANY-ADNIC
TPA : E CARE - Green Network
Validity : 01-01-1900 To 30-09-2024
Gender : Male
Date Of Birth : 30-Sep-1990
Patient's Tel No : 0563007824

Service Date : 12-Dec-2023
Health Provider : Irham Medical Center Arjan
Doctor's Name : Sajid Sanaullah
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
Remarks :

☐ Acute	☐ Pre-existing and chronic	☐ Maternity
Chief Complaints : Severe sore throat and cough started three days ago and severe shivering since 10/12/2023 severe left leg and knee pain started yesterday after falling in bathroom		
Vitals: Temp : 39.1 Bp :121 Pulse :101 Resp :22		
Clinical Findings:		
Diagnosis: J02.9 - Acute pharyngitis, unspecified,J20.9 - Acute bronchitis, unspecified,J03.90 - Acute tonsillitis, unspecified,S80.212A - Abrasion, left knee, initial encounter,R50.9 - Fever, unspecified,		Date of Onset : 12/04/2023
Requested Investigations: 9.01, Follow Up Consultation GP,0195-107704-0802, CEFTRIAXONE-TABUK IM,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,0005-149902-1021, CLOFEN ,96372, THER/PROPH/DIAG INJ SC/IM,94640, AIRWAY INHALATION TREATMENT,0188-135906-2441, PULMICORT,0006-124513-2071, VENTOLIN NEBULES		
Prescriptions: 0005-116801-1161 - (SODIUM CITRATE : 57 MG/5ML) (AMMONIUM CHLORIDE : 131.5 MG/5 ML) (MENTHOL : 1.1 MG/5 ML) (DIPHENHYDRAMINE : 13.5 MG/5ML) SYRUP,4179-711202-0391 - (IBUPROFEN (AS L-ARGININE SALT) : 400 MG) FILM COATED TABLETS,0097-127405-0392 - (AZITHROMYCIN : 500 MG) FILM COATED TABLETS,		
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

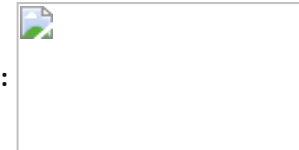
regarding my medical condition & history for purpose of
determining insurance benefits.

**Dr's
Name** : Sajid Sanaullah

Stamp :



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



Date : 12-
Dec-
2023

Signature :



Date : 12-Dec-2023