Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: DILAN SAMALKA SENANAYAKE KALUTARA KORALALAGE**	**Service Date**	**:21-Jul-2023**
Card No	**: I017-029-117490343-02**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	**: DILAN SAMALKA SENANAYAKE KALUTARA KORALALAGE**	**Doctor's Name**	**:Enomen Goodluck**
Payer Name	**: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:
TPA	**: E CARE - Green Network**	**Remarks**	:
Validity	**: 01-10-2022** To **30-09-2023**		
Gender	**: Male**		
Date Of Birth	**: 18-Sep-1990**		
Patient's Tel No	**: 0522946517**		

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 : Pain in throat, fever, dry cough, and difficulty in breathing. Not a known asthmatic. **Duration:**

Vitals: Temp : 37.3 Bp :100 Pulse :79 Resp :18

Clinical Findings:

Diagnosis: J20.9 - Acute bronchitis, unspecified,R05 - Cough,R06.00 - Dyspnea, unspecified,R07.0 - Pain in throat, **Date of Onset:**21/24/2023

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,0195-107704-0801, CEFTRIAXONE-TABUK IV,9, Consultation GP **Estimated Cost :**

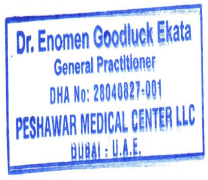
Prescriptions: 2118-290301-0391 - (LEVOCETIRIZINE (DIHCL OR HCL) : 5 MG) FILM COATED TABLETS,0005-124508-1173 - (SALBUTAMOL : 2 MG) TABLETS,0027-265801-1631 - (BUTAMIRATE DIHYDROGEN CITRATE : 0.5%) DROPS (ORAL),0696-107902-0392 - (IBUPROFEN : 400 MG) FILM COATED TABLETS,0252-185801-0391 - (DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS,0005-119805-1172 - (PREDNISOLONE : 5 MG) TABLETS, **Estimated Cost :**

MEDICAL PRACTITIONER DECLARATION :

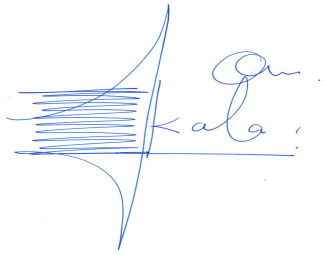
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

Dr's Name : Enomen Goodluck

Stamp :



Signature :



Date : 21-Jul-2023

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 : 21-Jul-2023