Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: MYA SU WAI PHUE**	**Service Date**	**:04-May-2024**
Card No	**: I017-029-117636642-02**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	**: MYA SU WAI PHUE**	**Doctor's Name**	**:SANDIA**
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	**: 31-Dec-1986**		
Patient's Tel No	**: 0582787784**		

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 : pt looks dehydrated, pt comes with abdomial pain since 2 days since teh period has startred, pt co period cramps with nauea. legs feeling weak body pain and very weak feel dizzy and weakness in legs **Duration:**

Vitals: Temp : 35.6 Bp :118 Pulse :68 Resp :22

Clinical Findings:

Diagnosis: M79.18 - Myalgia, other site, **Date of Onset** : 04/24/2024

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,96360, HYDRATION IV INFUSION INIT,9, Consultation GP,0102-100104-1001, SODIUM CHLORIDE & DEXTROSE B.P.-(SODIUM CHLORIDE : 0.9%) (DEXTROSE : 5%) SOLUTION FOR INFUSION **Estimated Cost** :

Prescriptions: **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.

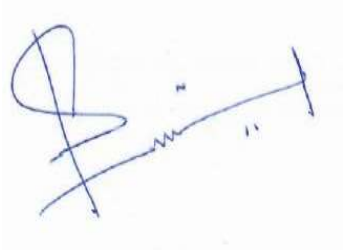
Dr's Name : SANDIA

Stamp :

Patient 's signature{Parent if minor} :

Date : 04-May-2024

Signature :



Date : 04-May-2024