Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: NATALIA DABROWSKA**
Card No	**: l011-029-119717184-1**
Policy Holder	**: NATALIA DABROWSKA**
Payer Name	**: AL SAGR NATIONAL INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 08-08-2023** To **31-07-2024**
Gender	**: Female**
Date Of Birth	**: 14-Jun-1990**
Patient's Tel No	**: 0528134206**

Service Date :08-May-2024 **Network : Green**

Health Provider :Irham Medical Center Arjan **Direct Access SP - YES**

Doctor's Name :Humaira

Co-Insurance :

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

Remarks :

☐ **Acute** ☐ **Pre-existing and chronic** ☐ **Maternity**

Chief Complaints : co weakness ill looking dehydrated h aving a history of iron deficiency anemia 2 years before and having same type of symptoms oe ill looking weak dehydrated fatiage advised two days rest **Duration:**

Vitals: Temp : 36.9 Bp :107 Pulse :82 Resp :22

Clinical Findings:

Diagnosis: D50.9 - Iron deficiency anemia, unspecified,E86.0 - Dehydration,R53.1 - Weakness, **Date of Onset :**08/21/2024

Requested Investigations: 0102-152902-1001, LACTATED RINGERS INJECTION USP,INJ014, INJ-NEUROBION VITAMIN B GROUPS,80051, ELECTROLYTE PANEL,101, GENARAL WELNES CHECKUP (55 TEST),96360, HYDRATION IV INFUSION INIT,9, Consultation GP **Estimated Cost :**

Prescriptions: 0097-230603-0831 - (ORAL REHYDRATION SALTS (O.R.S.) : N/A) POWDER FOR SOLUTION,7020-992601-1171 - (VITAMIN D (AS CHOLECALCIFEROL) : 5 MCG) (CHROMIUM : 25 MCG) (VITAMIN A (AS BETA CAROTENE) : 1200 MCG) (VITAMIN E : 4.5 MG) (BIOTIN : 30 MCG) (VITAMIN C (ASCORBIC ACID) : 45 MG) (RIBOFLAVIN : 1 MG) (MANGANESE : 1.8 MG) (VITAMIN B6 : 1.3 MG) (NIACINAMIDE : 14 MG) (SELENIUM : 20 MCG) (FOLIC ACID : 240 MCG) (MAGNESIUM : 100 MG) (IRON : 10 MG) (VITAMIN B12 : 2.4 MCG) (CALCIUM : 320 MG) (PANTOTHENIC ACID : 5 MG) (THIAMINE : 1 MG) (COPPER : 0.45 MG) (ZINC : 7 MG) (IODINE : 33 MCG) (VITAMIN K1 : 25 MC, **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

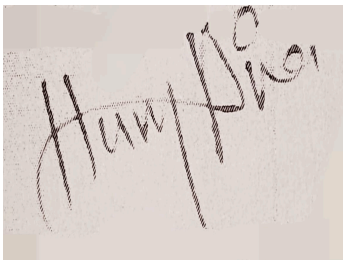
Stamp :

Dr. Humaira Mumtaz
General Practitioner
DHA No: 54155530-002
PESHAWAR MEDICAL CENTER LLC
DUBAI - U.A.E.

Patient 's signature{Parent if minor} :

Date : 08-May-2024

Signature :



Date : 08-May-2024