Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: SABRINA LAZARUS**	**Service Date**	**:29-May-2024**
Card No	**: I017-029-119843974-01**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	**: SABRINA LAZARUS**	**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	**: 03-Jun-2004**		
Patient's Tel No	**: 0553059518**		

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

Network : Green

Direct Access SP - YES

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

Chief Complaints : co bleeding through the vagina 4 pads yesterday today 2 [pads tilll now oe lower abdominal pain clots are coming chest is clear no added sounds **Duration:**

Vitals: Temp : 37.2 Bp :98 Pulse :84 Resp :18

Clinical Findings:

Diagnosis: N92.0 - Excessive and frequent menstruation with regular cycle,R10.30 - Lower abdominal pain, unspecified, **Date of Onset** :29/48/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0102-230603-0831 - (ORAL REHYDRATION SALTS (O.R.S.) : N/A) POWDER FOR SOLUTION,6792-956301-1171 - (VITAMIN B12 (CYANOCOBALAMIN) : 18 MCG) (VITAMIN D3 (CHOLECALCIFEROL) : 5 MCG) (VITAMIN E : 26.84 MG) (VITAMIN K1 : 25 MCG) (VITAMIN C (ASCORBIC ACID) : 120 MG) (BIOTIN : 40 MCG) (FOLIC ACID : 0.4 MG) (PANTOTHENIC ACID (CALCIUM PANTOTHENATE) : 10 MG) (IODINE (AS POTASSIUM IODIDE) : 0.15 MG) (CALCIUM (AS CARBONATE + CALCIUM PHOSPHATE DIBASIC) : 100 MG) (PHOSPHORUS (AS CALCIUM PHOSPHATE DIBASIC) : 48 MG) (MAGNESIUM(AS MAGNESIUM OXIDE) : 45 MG) (IRON (FERROUS FUMARATE) : 14 MG) (COPPER (AS SULPHATE,2212-156802-0391 - (TRANEXAMIC ACID : 500 MG) FILM COATED TABLETS,0016-181302-1171 - (MEFENAMIC ACID : 500 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

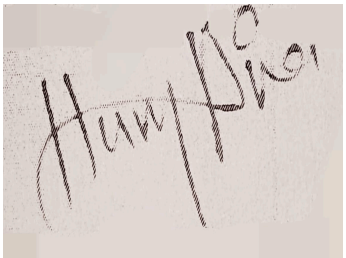
Stamp :

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

Patient 's signature{Parent if minor} :

Date : 29-May-2024

Signature :



Date : 29-May-2024