

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : PRAPATSORN KERDMARK
Card No : I017-029-117539996-02
Policy Holder : PRAPATSORN KERDMARK
Payer Name : ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC
TPA : E CARE - Green Network
Validity : 01-01-1900 To 30-09-2024
Gender : Female
Date Of Birth : 06-Sep-1990
Patient's Tel No : 566442706

Service Date : 11-Nov-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 : polyuria also persists and polydipsia also present, dysuria and chills since that time and severe pain in back, severe back pain and abdominal wall pain since one week started on 4/11/2023

Duration:

Vitals: Temp : 37.6 Bp :101 Pulse :99 Resp :22

Clinical Findings:

Diagnosis: M54.5 - Low back pain,M62.830 - Muscle spasm of back,N39.0 - Urinary tract infection, site not specified,R68.83 - Chills (without fever),Z13.1 - Encounter for screening for diabetes mellitus,

Date of Onset : 11/56/2023

Requested Investigations: 0102-100104-1001, SODIUM CHLORIDE & DEXTROSE B.P.,0195-107704-0801, CEFTRIAXONE-TABUK IV,0005-149902-1021, CLOFEN ,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,85651, SEDIMENTATION RATE RBC NON AUTOMATED,86140, C REACTIVE PROTEIN,81001, URNLS DIP STICK/TABLET REAGENT AUTO MICROSCOPY,87088, CULTURE BCT ISOL&PRSMPTV ID ISOLATE EA URINE,82948, REAGENT STRIP/BLOOD GLUCOSE,9, Consultation GP

Estimated : Cost

Prescriptions: 0046-149901-0431 - (DICLOFENAC SODIUM : 1%) GEL,4417-711202-0391 - (IBUPROFEN (AS L-ARGININE SALT) : 400 MG) FILM COATED TABLETS,0097-103201-0391 - (CIPROFLOXACIN : 500 MG) FILM COATED 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 :

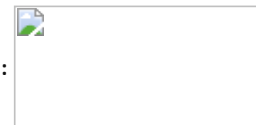
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Sajid Sanaullah

Stamp :



Patient's signature{Parent : if minor}



Date : 11-Nov-2023

Signature :

Date : 11-Nov-2023