Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: PRAPATSORN KERDMARK**	**Service Date**	**:11-Nov-2023**	**Network**	**:** Green
Card No	**: I017-029-117539996-02**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	**: PRAPATSORN KERDMARK**	**Doctor's Name**	**:Sajid Sanaullah**		
Payer Name	**: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:		
TPA	**: E CARE - Green Network**	**Remarks**	:		
Validity	**: 01-01-1900** To **30-09-2024**				
Gender	**: Female**				
Date Of Birth	**: 06-Sep-1990**				
Patient's Tel No	**: 566442706**				

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 : 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