

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 : 0506965824

Service Date : 12-Nov-2023

Health Provider : Irham Medical Center Arjan

Doctor's Name : Sajid Sanaullah

Network : Green

Direct Access SP - YES

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 : High ESR =100 High CRP =80 also anemia and severe sepsis due to urine infection

Vitals:

Clinical Findings:

Diagnosis: A41.50 - Gram-negative sepsis, unspecified,N10 - Acute pyelonephritis,D64.9 - Anemia, unspecified, Date of Onset:12/33/2023

Requested Investigations: 0102-100104-1001, SODIUM CHLORIDE & DEXTROSE B.P.,0195-107704-0801, CEFTRIAXONE-TABUK IV,96374, THER/PROPH/DIAG INJ IV PUSH,96360, HYDRATION IV INFUSION INIT,9.01, Follow Up Consultation GP

Estimated :
Cost

Prescriptions: 1838-538801-1021 - (FERRICÂ CARBOXYMALTOSE : 50 MG/ML) SOLUTION FOR INJECTION,0097-103201-0392 - (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 :

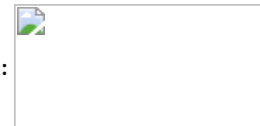
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Sajid Sanaullah

Stamp :



Patient's signature{Parent : if minor}

12-
Date : Nov-
2023

Signature :

Date : 12-Nov-2023