Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: PRAPATSORN KERDMARK**	**Service Date**	**:12-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	**: 0506965824**				

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

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} :

Date : 12-Nov-2023

Signature :

Date : 12-Nov-2023