Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: DEEPIKA PANCHAKOTI**	**Service Date**	**:15-Nov-2023**	**Network**	**:** Green
Card No	**: I017-029-115381333-02**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	**: DEEPIKA PANCHAKOTI**	**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-May-1991**				
Patient's Tel No	**: 0558385662**				

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 : urine analysis has pas and infected **Duration :**

Vitals: Temp : 36.8 Bp :112 Pulse :86 Resp :22

Clinical Findings:

Diagnosis: N10 - Acute pyelonephritis,N30.01 - Acute cystitis with hematuria, **Date of Onset :**15/46/2023

Requested Investigations: 0195-107704-0802, CEFTRIAXONE-TABUK IM,96372, THER/PROPH/DIAG INJ SC/IM,9.01, Follow Up Consultation GP **Estimated Cost :**

Prescriptions: 0139-116207-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 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 : Sajid Sanaullah **Stamp :**

Dr. Sajid Sanaullah Khan
General Practitioner
DHA No: 05758224-001
PESHAWAR MEDICAL CENTER LLC
DUBAI - U.A.E.

Patient 's signature{Parent : if minor}

Date : 15-Nov-2023

Signature : 

Date : 15-Nov-2023