Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: ZIPPORAH KAIRUU NJERI**	**Service Date**	**:28-Dec-2023**
Card No	**: I017-029-115381336-02**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	**: ZIPPORAH KAIRUU NJERI**	**Doctor's Name**	**:Sajid Sanaullah**
Payer Name	**: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:
TPA	**: E CARE - Green Network**	**Remarks**	**:**
Validity	**: 01-10-2023** To **30-09-2024**		
Gender	**: Female**		
Date Of Birth	**: 24-Apr-1989**		
Patient's Tel No	**: 0582652921**		

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

Network : Green

Direct Access SP - YES

☐ **Acute** ☐ **Pre-existing and chronic** ☐ **Maternity**

Chief Complaints : iron defiviency anemia FERRITIN 9 IRON SERUM 21 TIBC 344 PATIENT HAS WEAKNESS AND ALSO SHE HAS LOSS OF HAIR FREQUENTLY AND ALSO SHE HAS FEEL OF WEAKNES EVERY DAY **Duration:**

Vitals:

Clinical Findings:

Diagnosis: D50.9 - Iron deficiency anemia, unspecified,R53.1 - Weakness,L65.9 - Nonscarring hair loss, unspecified,R20.2 - Paresthesia of skin, **Date of Onset** :28/30/2023

Requested Investigations: 9.01, Follow Up Consultation GP,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,0005-111805-1021, CHLOROHISTOL 10MG-(CHLORPHENIRAMINE MALEATE : 10 MG/ML) SOLUTION FOR INJECTION,0102-111908-1001, SODIUM CHLORIDE B.P.-(SODIUM CHLORIDE : 0.9% W/V) SOLUTION FOR INFUSION,96360, HYDRATION IV INFUSION INIT,96365, THER/PROPH/DIAG IV INF INIT,96365, IV INFUSION THERAPY -Antibiotics & Others **Estimated Cost** :

Prescriptions: 1650-550901-0061 - (ASCORBIC ACID (VITAMIN C) : 70 MG) (LIPOSOMAL IRON : 30 MG) CAPSULES, **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 : 28-Dec-2023

Signature :

Date : 28-Dec-2023