Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **CHERYL MELISSA CORDEIRO JERAMIAS EMMANUEL CORDEIRO**	**Service Date**	**:19-Jan-2024**
Card No	: **I017-029-118740283-01**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	: **CHERYL MELISSA CORDEIRO JERAMIAS EMMANUEL CORDEIRO**	**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	: **13-May-1995**		
Patient's Tel No	: **971507847524**		

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 : C/O PAIN IN LOWER ABDOMEN , VAGINAL DISCHARGE AND BURNING MICTURATION H/O PCOS SINCE 4 YEARS ,CURRENTLY TAKING MEDICINES FOR THID FROM HER HOME COUNTRY DR **Duration:**

Vitals: Temp : 36.5 Bp :123 Pulse :88 Resp :22

Clinical Findings:

Diagnosis: N77.1 - Vaginitis, vulvitis and vulvovaginitis in dis classd elswhr,N39.0 - Urinary tract infection, site not specified,R10.9 - Unspecified abdominal pain,B37.3 - Candidiasis of vulva and vagina, **Date of Onset** :19/37/2024

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,81001, URNLS DIP STICK/TABLET REAGENT AUTO MICROSCOPY,84704, HCG FREE BETACHAIN TEST,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP,84704, HCG FREE BETACHAIN TEST **Estimated Cost** :

Prescriptions: 0005-252201-0391 - (CAFFEINE : 65 MG) (IBUPROFEN : 400 MG) FILM COATED TABLETS,3114-482003-0391 - (CIPROFLOXACIN (AS HYDROCHLORIDE) : 500 MG) FILM COATED TABLETS,0152-116604-0391 - (METRONIDAZOLE : 500 MG) FILM COATED TABLETS,0207-140504-0151 - (CLOTRIMAZOLE : 1%) CREAM, **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 : 19-Jan-2024

Signature :

Date : 19-Jan-2024