Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: ZIPPORAH KAIRUU NJERI**	**Service Date**	**:15-Feb-2024**	**Network**	**:** Green
Card No	**: I017-029-115381336-02**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
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

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

Chief Complaints : **Duration :**

Vitals: Temp : 36.7 Bp :122 Pulse :82 Resp :18

Clinical Findings:

Diagnosis: D50.9 - Iron deficiency anemia, unspecified,R53.1 - Weakness, **Date of Onset :**15/34/2024

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,83540, IRON,83550, IRON BINDING CAPACITY,9, Consultation GP **Estimated Cost :**

Prescriptions: 0252-182201-0081 - (FOLIC ACID : 0.35 MG) (IRON (AS FERRIC/FERROUS HYDROXIDE POLYMALTOSE COMPLEX) : 100 MG) CHEWABLE TABLETS,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 : 15-Feb-2024

Signature :

Date : 15-Feb-2024