Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: UJWALA PANDURANG SHELKE PANDURANG DASHRATH SHELKE**
Card No	**: I017-029-117009982-02**
Policy Holder	**: UJWALA PANDURANG SHELKE PANDURANG DASHRATH SHELKE**
Payer Name	**: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**
TPA	**: E CARE - Green Network**
Validity	**: 01-10-2023** To **30-09-2024**
Gender	**: Female**
Date Of Birth	**: 18-Feb-1997**
Patient's Tel No	**: 0503449424**

Service Date **:22-Mar-2024** **Network** : Green

Health Provider **:Irham Medical Center Arjan** **Direct Access SP - YES**

Doctor's Name **:Enomen Goodluck**

Co-Insurance :

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

Remarks :

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

Chief Complaints : Recurrent difficulty breathing, chest pain and all symptoms are worst when in the cold as in under the air condition. This morning she woke of with weakness and fever. Also complained of low back pain probably due to to prolonged hours of standing, Has a history of anemia Exam: looks malnourished and pale. Abdomen: marked epigastric tenderness with bilateral flank pain. **Duration:**

Vitals: Temp : 36.7 Bp :117 Pulse :90 Resp :24

Clinical Findings:

Diagnosis: K29.00 - Acute gastritis without bleeding,N10 - Acute pyelonephritis,R50.9 - Fever, unspecified,R53.1 - Weakness,D50.9 - Iron deficiency anemia, unspecified, **Date of Onset** :22/29/2024

Requested Investigations: 81001, URNLS DIP STICK/TABLET REAGENT AUTO MICROSCOPY,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,9, Consultation GP **Estimated Cost** :

Prescriptions: 0252-182103-0082 - (IRON (AS FERRIC/FERROUS HYDROXIDE POLYMALTOSE COMPLEX) : 100 MG) CHEWABLE TABLETS,0252-106601-1172 - (PARACETAMOL : 500 MG) TABLETS,0188-232402-0391 - (ESOMEPRAZOLE : 20 MG) FILM COATED TABLETS,0097-103201-0391 - (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 : Enomen Goodluck **Stamp :**

Dr. Enomen Goodluck Ekata
General Practitioner
DHA No: 28040827-001
PESHAWAR MEDICAL CENTER LLC
DUBAI : U.A.E.

Patient 's signature{Parent : if minor} **Date :** 22-Mar-2024

Signature : **Date** : 22-Mar-2024