Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: KHIN BHONE TINT**	**Service Date**	**:21-Jul-2023**	**Network**	**:** Green
Card No	**: I017-029-119479748-01**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	**: KHIN BHONE TINT**	**Doctor's Name**	**:Sajid Sanaullah**		
Payer Name	**: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:		
TPA	**: E CARE - Green Network**	**Remarks**	:		
Validity	**: 05-06-2023** To **30-09-2023**				
Gender	**: Female**				
Date Of Birth	**: 15-Sep-1997**				
Patient's Tel No	**: 0556694781**				

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 : High fever and body pain started 20/07/2023 and unable to walk **Duration :**

Vitals: Temp : 37.4 Bp :100 Pulse :86 Resp :20

Clinical Findings:

Diagnosis: A49.9 - Bacterial infection, unspecified,R50.9 - Fever, unspecified,N10 - Acute pyelonephritis, **Date of Onset :**21/46/2023

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,85651, SEDIMENTATION RATE RBC NON AUTOMATED,86140, C REACTIVE PROTEIN,81015, URINALYSIS MICROSCOPIC ONLY,2849-100143-0991, 5% W/V DEXTROSE 0.45% & W/V SODIUM CHLORIDE,0195-107704-0801, CEFTRIAXONE-TABUK IV,0005-149902-1021, CLOFEN ,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,96360, HYDRATION IV INFUSION INIT,96374, THER/PROPH/DIAG INJ IV PUSH,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION **Estimated Cost :**

Prescriptions: 1351-106316-0271 - (ASCORBIC ACID (VITAMIN C) : 550 MG) EFFERVESCENT TABLETS,0278-107902-0391 - (IBUPROFEN : 400 MG) FILM COATED TABLETS,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 : 21-Jul-2023

Signature :

Date : 21-Jul-2023