

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : KHIN BHONE TINT

Card No : I017-029-119479748-01

Policy Holder : KHIN BHONE TINT

Payer Name : ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC

TPA : E CARE - Green Network

Validity : 05-06-2023 To 30-09-2023

Gender : Female

Date Of Birth : 15-Sep-1997

Patient's Tel No : 0556694781

Service Date :21-Jul-2023

Health Provider :Irham Medical Center Arjan

Doctor's Name :Sajid Sanaullah

Co-Insurance :

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

Remarks :

Network : Green

Direct Access SP - YES

☐ Acute

☐ Pre-existing and chronic

☐ Maternity

Chief Complaints : High fever and body pain started 20/07/2023 and unable to walkDuration :

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 INFUSIONEstimated : 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.

Dr's Name : Sajid Sanaullah

Stamp :

Dr. Sajid Sanaullah Khan

General Practitioner

DHA No: 05758224-001

PESHAWAR MEDICAL CENTER LLC

DUBAI - U.A.E.

Signature :

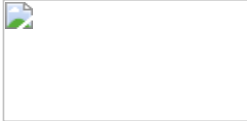


Date : 21-Jul-2023

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.

Patient 's signature{Parent : if minor}



21-Jul-2023