



Reimbursement claim form

This claim form is not an admission of liability.

Please use a separate claim form for each separate visit to the doctor.

Date Received:

Prior Approval No

Dear Doctor, we thank you for filling in medical sections B, C and D of this claim form and for signing, dating and stamping it. Dear Member, we thank you for completing all other sections of this claim form and for signing and dating it. All fields on the front page are compulsory. We thank you in advance for your cooperation which will enable fast and accurate processing.

A. Administrative

Membership No : 13/XC/35596/0	Group Name/ Company Name : Irham Medical Center Arjan	
Patient DOB: 17-Jun-1992	Gender : Female	Patient Name : FATIMA ALZAHRA AMIN MAHMOUD ASSAD
Policy/ Group No.#: Plan : Patient Phone : 0509765667		
Date Of Treatment : 27-May-2024 Admission Date: 27-May-2024 Discharge Date : 27-May-2024		
Email Address : info.albidaya@gmail.com		

B. Medical Section

Symptoms Presented

C/o: upper abdominal pain since last week

also has been having diarrhea since last night,

'stool is watery, non bloody and not mucoid.

Date the patient first became aware of any signs or symptoms for this condition:

Date on which the patient first presented to any doctor for this condition::

she is not a known hypertensive and not diabetic. and has no other medical condition in the past.

has previously been diagnosed of H. pylori infection in the past.

Medical Condition/ Diagnosis:

Date	Doctor	ICD Code	Diagnosis	Notes
27-May-2024	Enomen Goodluck	N39.0	Urinary tract infection, site not specified	
27-May-2024	Enomen Goodluck	R10.10	Upper abdominal pain, unspecified	
27-May-2024	Enomen Goodluck	R19.7	Diarrhea, unspecified	
27-May-2024	Enomen Goodluck	A09	Infectious gastroenteritis and colitis, unspecified	
27-May-2024	Enomen Goodluck	K29.00	Acute gastritis without bleeding	

Investigations((Describe necessary investigations requested to define the diagnosis):

Start Time	End Time	CPT Code	Treatment	Teeth No	Surface	Notes
00:00:00	00:00:00	96360	Intravenous infusion hydration initial 31 minutes to 1 hour	NA	NA	
00:00:00	00:00:00	0005-242802-0781	PANTONIX 40MG I.V.	NA	NA	
00:00:00	00:00:00	0005-136504-1021	SCOPINAL	NA	NA	

Start Time	End Time	CPT Code	Treatment	Teeth No	Surface	Notes
00:00:00	00:00:00	85025	COMPLETE BLOOD COUNT (CBC) BLOOD	NA	NA	
00:00:00	00:00:00	81001	ROUTINE EXAMINATION URINE	NA	NA	
00:00:00	00:00:00	9	GP Consultation	NA	NA	

C. Treatments Advised:

Drugs:

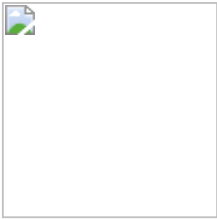
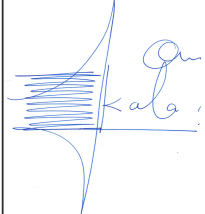
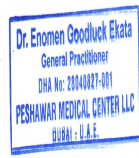
Generic/Dose/Form	Instructions	Duration	Quantity	Refill
PREMOSAN / (METOCLOPRAMIDE : 10 MG) TABLETS ORAL / TABLETS (20S, BLISTER PACK) / Tablets	Take 1Tablets 2 Time(s) per Day For 3 Day(s) others	3	6	
MOXAL PLUS / (ALUMINIUM HYDROXIDE : 200 MG) (MAGNESIUM HYDROXIDE : 200 MG) (SIMETHICONE : 25 MG) CHEWABLE TABLETS ORAL / CHEWABLE TABLETS (50S, BLISTER PACK) / Tablets	Take 1Tablets 4 Time(s) per Day For 5 Day(s) others	5	20	
CIPROBAY / (CIPROFLOXACIN : 500 MG) FILM COATED TABLETS ORAL / FILM COATED TABLETS (10S, BLISTER PACK) / Tablets	Take 1Tablets 2 Time(s) per Day For 5 Day(s) after meal	5	10	
NEXIUM / (ESOMEPRAZOLE : 40 MG) FILM COATED TABLETS ORAL / FILM COATED TABLETS (14S, BLISTER PACK) / Tablets	Take 1Tablets 2 Time(s) per Day For 14 Day(s) after meal	14	28	

Procedure(Please give details of medical procedures if any):

D. Further Treatment Plan

E. Other Issuer Details :

Is the Treatment Accident Related ? ☐ Yes ☐ No	Is it covered under another insurance policy? ☐ Yes ☐ No
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Patient Declaration	Medical practitioner declaration
I confirm I am the patient, patient's parent or guardian (if patient under 16 years of age) and wish to claim and declare that all the particulars given above are to the best of my knowledge true and correct. I hereby consent to and authorise the medical practitioner involved in the patient's care to discuss treatment details and discharge arrangements with and to AXA Insurance. I agree that a copy of this consent shall have the validity of the original.	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. Name : Enomen Goodluck
Signature : 	Signature & Stamp:   27-May-2024

F. Administrative specific to reimbursement claims

Amount Claimed: Please ensure that the amount claimed here is supported by original invoices and prescription
Cheque beneficiary name: (IN CAPITAL LETTERS)

Payment will be made in the currency defined in your plan unless we agreed otherwise in writing. In which currency was the treatment originally billed?

Member's and Patient Details : Patient Name and Address:

Telephone : Fax :

Address to which payment should be sent if different from above:

G. Medical Provider Details:

Name of medical Provider: **Irham Medical Center Arjan** Address : **Al salam Building, Al Barsha South, Arjan Near Miracle Garden, Dubai, United Arab Emirates.** Telephone : **047700948** fax : **042974343**

H. If you are claiming for treatment received outside your area of cover, please answer the following questions:

(a). Country where the treatment took place

(b). The reason for the patient being abroad

(c). Date of departure and return to own area of cover: From : to

Are you claiming cash benefit for in-patient treatment? Please tick ☐ Yes ☐ No

If Yes, please enclose a hospital certificate confirming the dates of stay:

I. Payment details for bank transfer:

Bank Account Number :

Bank Name :

Bank Address :

Beneficiary Name:

Bank Sort/Swift Code :

AXA Use only

Batch No. : Batch Opening Date: