Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: SABRINA LAZARUS**	**Service Date**	**:04-Jun-2024**	**Network**	**:** Green
Card No	**: I017-029-119843974-01**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	**: SABRINA LAZARUS**	**Doctor's Name**	**:Humaira**		
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	**: 03-Jun-2004**				
Patient's Tel No	**: 0553059518**				

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 : co vomitting 2 episode weak ill looking p-ain in epigastric region 1 days oe chest is clrear no added sounds **Duration:**

Vitals: Temp : 36.9 Bp :109 Pulse :99 Resp :18

Clinical Findings:

Diagnosis: R11.10 - Vomiting, unspecified,R10.13 - Epigastric pain,R53.1 - Weakness,K29.00 - Acute gastritis without bleeding, **Date of Onset** **:**04/46/2024

Requested Investigations: 9.01, Follow Up Consultation GP,86140, C REACTIVE PROTEIN,85652, SEDIMENTATION RATE RBC AUTOMATED,0195-107704-0801, CEFTRIAXONE-TABUK IV,0005-242802-0781, PANTONIX 40MG I.V.-(PANTOPRAZOLE (AS SODIUM) : 40 MG) POWDER FOR INFUSION,0005-150403-1021, PREMOSAN -(METOCLOPRAMIDE : 10 MG/2ML) SOLUTION FOR INJECTION,0102-152902-1001, LACTATED RINGERS INJECTION USP-(CALCIUM CHLORIDE : N/A) (POTASSIUM CHLORIDE : N/A) (SODIUM CHLORIDE : N/A) (SODIUM LACTATE : N/A) SOLUTION FOR INFUSION,96374, THER/PROPH/DIAG INJ IV PUSH,96372, THER/PROPH/DIAG INJ SC/IM,96360, HYDRATION IV INFUSION INIT,96365, THER/PROPH/DIAG IV INF INIT **Estimated Cost :**

Prescriptions: 0005-168202-1111 - DOMPERIDONE,0195-116604-0391 - (METRONIDAZOLE : 500 MG) FILM COATED TABLETS,4235-242802-1751 - (PANTOPRAZOLE (AS SODIUM) : 40 MG) GASTRO-RESISTANT TABLETS,0219-142902-1452 - (CEFIXIME : 400 MG) CAPSULES (HARD GELATIN), **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.

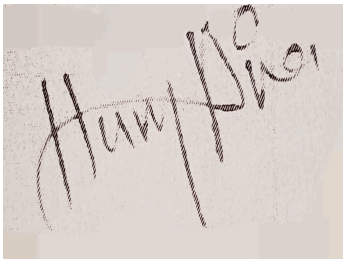
PATIENT'S DECLARATION :

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 : Humaira **Stamp :**

Dr. Humaira Mumtaz
General Practitioner
DHA No: 54155530-002
PESHAWAR MEDICAL CENTER LLC
DUBAI - U.A.E.

Patient 's signature{Parent if minor} : **Date :** 04-Jun-2024

Signature :  **Date :** 04-Jun-2024