DirectThsclaimformBillingisnotan admissionClaim ofFormliability

Administrative Section

Policy number	13/XC/36002/0/141/E/0	Membership number	
Patient name	AHMEDAHMED MOHAMEDASIF GODIL GODIL MOHAMEDASIF ABDULLAH	Provider name	CITICARE MEDICAL CENTER LLC
Date of treatment	30-Aug-2024	Patient Gender	◉ Male ○ Female

Medical Section

Type of visit ☐ **Outpatient** ☐ **Inpatient If** ☐ **Emergency** ☐ **Maternity** ☐ **Dental** ☐ **Optical**

If Pregnant: L.M.P. Date Nature of conception ○ **Natural** ○ **Assisted**

Chief complaint

PC: SVERE EPIGASTRIC PAIN

NAUSEA AND VOMITING

History of present illness

Date	Doctor	Location	Quality	Severity	Duration	Timing	Context	Modifying Factor	Symptoms
No Previous Complaints Found									

Clinical findings/other conditions

Past medical history

Details of trauma - if applicable (where, when & how) ☐ **Work Related** ☐ **RTA Related** ☐ **Sports Related**

If yes ○ **Professional** ○ **Non-Professional**

Diagnosis

K29.00 - Acute gastritis without bleeding, R10.13 - Epigastric pain

Treatment plan, recommended medications, investigations, and/or procedures

Treatments: 0005-174202-0781, RISEK 40MG,0005-150403-1021, PREMOSAN -(METOCLOPRAMIDE : 10 MG/2ML) SOLUTION FOR INJECTION,0005-136504-1021, SCOPINAL-(HYOSCINE : 20 MG/ML) SOLUTION FOR INJECTION,0102-100104-1001, SODIUM CHLORIDE & DEXTROSE B.P.,96365, Intravenous infusion for therapy prophylaxis or diagnosis (specify substance or drug) initial up to,9, GP Consultation

Prescription:0252-150407-1171 - (METOCLOPRAMIDE : 10 MG) TABLETS,0005-136501-0393 - (HYOSCINE : 10 MG) FILM COATED TABLETS,0207-533801-1451 - (ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) CAPSULES (HARD GELATIN),

Patient declaration

I hereby confirm that I am the patient/AXA card holder, Patient's parent or guardian (if under 16 years of age) and I wish to claim and declare that all the details/ information given above are to the best of my knowledge true and correct. I hereby consent to and fully authorize the medical practitioner involved in the patient's care to discuss treatment details and discharge arrangements with and to AXA Insurance (Gulf) B.S.C © representative or any of AXA company affiliates. I subrogate all my rights in relation to this claim and I fully authorize and give access to AXA Insurance (Gulf) B.S.C © representative or any of AXA company affiliates to audit, review and copy all my medical records details including any historical medical records regardless the previous payer/insurer. I agree that a copy of this consent shall have the validity of the original.

Signature Date:30-Aug-2024

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.

Name

Signature Date:30-Aug-2024

Stamp

Dr. Ahsan Hussain
General Practitioner
DHA No: 87543658-001
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

WARNING:Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony. Penalties may include but not be restricted to denial of insurance benefits / cover, rendering the insurance contract void and/or legal action to be taken where deemed necessary.

If you have any questions regarding this form or any other aspects of the cover, please contact AXA on UAE +971 (4) 429 4000, Qatar +97 4 412 8733, Bahrain +973 (17) 582 612, KSA +966 (1) 478 0282 quoting the policy and membership numbers. Claims must be submitted along with supporting documents within 30 days from date of service. Send this claim form together with supporting material to Medical Department, AXA Insurance, PO BOX 32505, Dubai, UAE or AXA Insurance, P.O. Box 45, Kingdom of Bahrain or AXA Insurance PO BOX 21044, 11475 Riyadh, Kingdom of Saudi Arabia or AXA Insurance, PO Box 15319, Doha, State of Qatar.