

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : PETER GITAH MBURU

Card No : I017-029-119384583-01

Policy Holder : PETER GITAH MBURU

Payer Name : ABU DHABI NATIONAL
INSURANCE COMPANY-ADNIC

TPA : E CARE - Green Network

Validity : 01-10-2023 To 30-09-2024

Gender : Male

Date Of Birth : 24-Sep-1997

Patient's Tel No : 971566442706

Service Date : 28-Nov-2023

Health Provider : Irham Medical Center Arjan

Doctor's Name : Sajid Sanaullah

Network : Green

Direct Access SP - YES

Co-Insurance :

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

Remarks :

☐ Acute
☐ Pre-existing and chronic
☐ Maternity

Chief Complaints : stomach pain and 2 time vomiting from last night 27/11/2023 Duration :

Vitals:Temp : 36.6 Bp :118 Pulse :91 Resp :22

Clinical Findings:

Diagnosis: K27.3 - Acute peptic ulcer, site unsp, w/o hemorrhage or perforation,A05.1 - Botulism food poisoning,A09 - Infectious gastroenteritis and colitis, unspecified,

Date of Onset : 28/30/2023

Requested Investigations: 0102-152902-1001, LACTATED RINGERS INJECTION USP,0005-136504-1021, Estimated :
SCOPINAL,0005-149902-1021, CLOFEN ,96360, HYDRATION IV INFUSION INIT,9, Consultation Cost
GP,96372, THER/PROPH/DIAG INJ SC/IM,96365, THER/PROPH/DIAG IV INF INIT,96372,
THER/PROPH/DIAG INJ SC/IM,96360, HYDRATION IV INFUSION INIT

Estimated Cost :

Prescriptions: 0170-116609-1171 - (METRONIDAZOLE : 400 MG) TABLETS,

MEDICAL PRACTITIONER DECLARATION :

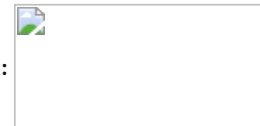
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

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 :


 Patient's signature {Parent :
if minor}

 28-
Date : Nov-
2023

Signature :

Date : 28-Nov-2023