Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: FUSSEL LUGO**	**Service Date**	**:17-Dec-2023**
Card No	**: I017-029-117079201-02**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	**: FUSSEL LUGO**	**Doctor's Name**	**:Sajid Sanaullah**
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	**: Male**		
Date Of Birth	**: 03-Apr-1980**		
Patient's Tel No	**: 0527229677**		

Network : Green

Direct Access SP - YES

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 : Severe stomach pain started yesterday 15/12/20223 history of gastritis since **Duration:** 15/10/2023

Vitals: Temp : 36.7 Bp :118 Pulse :69 Resp :22

Clinical Findings:

Diagnosis: K29.00 - Acute gastritis without bleeding,R11.2 - Nausea with vomiting, unspecified,K21.9 - Gastro-esophageal reflux disease without esophagitis, **Date of Onset** :17/57/2023

Requested Investigations: 0102-100104-1001, SODIUM CHLORIDE & DEXTROSE B.P.,0005-242802-0781, PANTONIX 40MG I.V.-(PANTOPRAZOLE (AS SODIUM) : 40 MG) POWDER FOR INFUSION,0005-150403-1021, PREMOSAN ,96360, HYDRATION IV INFUSION INIT,96374, THER/PROPH/DIAG INJ IV PUSH,87338, IAAD EIA HPYLORI STOOL,9, Consultation GP **Estimated Cost** :

Prescriptions: 0435-189401-1113 - (CALCIUM CARBONATE : N/A) (SODIUM BICARBONATE : N/A) (SODIUM ALGINATE : N/A) SUSPENSION,0031-168201-0391 - (DOMPERIDONE : 10 MG) FILM COATED TABLETS,0669-242802-3261 - (PANTOPRAZOLE (AS SODIUM) : 40 MG) DELAYED RELEASE TABLET, **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 : Sajid Sanaullah

Stamp :

Patient 's signature{Parent if minor} :

Date : 17-Dec-2023

Signature :

Date : 17-Dec-2023