

Administrative**MEDICAL CLAIM FORM****Claim Ref:****Patient Name** : ARIJ BEN ZINEB**Card No** : I017-029-119290084-01**Policy Holder** : ARIJ BEN ZINEB**Payer Name** : ABU DHABI NATIONAL
INSURANCE COMPANY-
ADNIC**TPA** : E CARE - Blue Network**Validity** : 01-01-1900 To 11-04-2024**Gender** : Female**Date Of Birth** : 14-Nov-1994**Patient's Tel No** : 971581248311**Service Date** :26-Dec-2023**Health Provider** :Irham Medical Center Arjan**Doctor's Name** :Sajid Sanaullah**Co-Insurance** :

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

Network : Green**Direct Access SP - YES****Remarks** :

☐ Acute	☐ Pre-existing and chronic	☐ Maternity
Chief Complaints : esophagial reflux, gastritis, gastric pain, dry and wet cough		
Duration :		
Vitals: Temp : 36.9 Bp :107 Pulse :82 Resp :22		
Clinical Findings:		
Diagnosis: K21.9 - Gastro-esophageal reflux disease without esophagitis,K29.70 - Gastritis, unspecified, without bleeding,K30 - Functional dyspepsia,R05 - Cough,J01.91 - Acute recurrent sinusitis, unspecified,G47.9 - Sleep disorder, unspecified,		
Date of Onset :26/04/2023		
Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,87338, IAAD EIA HPYLORI STOOL,86677, ANTIBODY HELICOBACTER PYLORI,9, Consultation GP		
Estimated Cost :		
Prescriptions: 1505-345306-0061 - (MELATONIN : 5 MG) CAPSULES,0195-183202-0391 - (FEXOFENADINE HCL : 180 MG) FILM COATED TABLETS,0430-161101-1172 - (BISMUTH SUBCITRATE : 120 MG) TABLETS,0097-397801-0392 - (DOMPERIDONE (AS MALEATE) : 10 MG) FILM COATED TABLETS,0155-132303-1451 - (MEBEVERINE : 200 MG) CAPSULES (HARD GELATIN),4884-632002-1751 - (PANTOPRAZOLE (AS SODIUM SESQUIHYDRATE) : 40 MG) GASTRO-RESISTANT TABLETS,		
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		

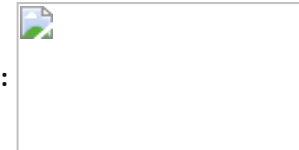
regarding my medical condition & history for purpose of
determining insurance benefits.

**Dr's
Name** : Sajid Sanaullah

Stamp :



**Patient 's
signature{Parent :
if minor}**



Date : 26-
Dec-
2023

Signature :

A handwritten signature in blue ink, appearing to be "Sajid Sanaullah Khan".

Date : 26-Dec-2023