Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: ARIJ BEN ZINEB**	**Service Date**	**:12-Jan-2024**	**Network**	**:** Green
Card No	**: I017-029-119290084-01**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	**: ARIJ BEN ZINEB**	**Doctor's Name**	**:Sajid Sanaullah**		
Payer Name	**: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:		
TPA	**: E CARE - Blue Network**	**Remarks**	**:**		
Validity	**: 01-01-1900** To **11-04-2024**				
Gender	**: Female**				
Date Of Birth	**: 14-Nov-1994**				
Patient's Tel No	**: 971581248311**				

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 : he has the pain since more than one month which is more worsening when she is fasting and also she has gastro esophagial reflux also she has pain in her epigastric area while having physical examination and she hast also the same history in her first family member which has been diagnosed as h.pylori infection **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, **Date of Onset** :12/01/2024

Requested Investigations: 9, Consultation GP **Estimated Cost** :

Prescriptions: 0031-168201-0391 - (DOMPERIDONE : 10 MG) FILM COATED TABLETS,0188-232401-0392 - (ESOMEPRAZOLE : 40 MG) FILM COATED 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.

Dr's Name : Sajid Sanaullah **Stamp :**

Dr. Sajid Sanaullah Khan
General Practitioner
DHA No: 05758224-001
PESHAWAR MEDICAL CENTER LLC
DUBAI - U.A.E.

Signature :  **Date** : 12-Jan-2024

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.

Patient 's signature{Parent if minor} :  **Date :** 12-Jan-2024