

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 :12-Jan-2024
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 : he has the pain since more than one month which is more worsening when she is fasting and also she has gastro esophageal reflux also she has pain in her epigastric area while having physical examination and she has also the same history in her first family member which has been diagnosed as h.pylori infection

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.

PATIENT'S DECLARATION :

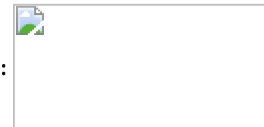
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Sajid Sanaullah

Stamp :



Patient's signature{Parent : if minor}



12-
Date : Jan-
2024

Signature :

Date : 12-Jan-2024