Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: ZUHAYR ALI**	**Service Date**	**:15-Jan-2024**	**Network**	: Green
Card No	**: I017-029-116381377-02**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	**: ZUHAYR ALI**	**Doctor's Name**	**:Mohammadmahdi**		
Payer Name	**: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:		
TPA	**: E CARE - Blue Network**	**Remarks**	:		
Validity	**: 26-01-2023** To **25-01-2024**				
Gender	**: Male**				
Date Of Birth	**: 28-Feb-2018**				
Patient's Tel No	**: 0563097844**				

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 VOMITING AND ABDOMINAL PAIN SINCE YESTERDAY 14/1/2024 SEVERE GASTRITIS AND LOSS OF APPETITE **Duration:**

Vitals: Temp : 36.8 Bp :0 Pulse :96 Resp :26

Clinical Findings:

Diagnosis: K29.00 - Acute gastritis without bleeding,R11.2 - Nausea with vomiting, unspecified, **Date of Onset** :15/03/2024

Requested Investigations: 10, Consultation Specialist,0102-100104-1001, SODIUM CHLORIDE & DEXTROSE B.P.,0005-150403-1021, PREMOSAN ,0005-242802-0781, PANTONIX 40MG I.V.,96360, HYDRATION IV INFUSION INIT,96374, THER/PROPH/DIAG INJ IV PUSH **Estimated Cost** :

Prescriptions: 0188-232403-0461 - (ESOMEPRAZOLE : 10 MG) GRANULES FOR RECONSTITUTION,0031-168202-1111 - (DOMPERIDONE : 1 MG/ML) SUSPENSION, **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 :

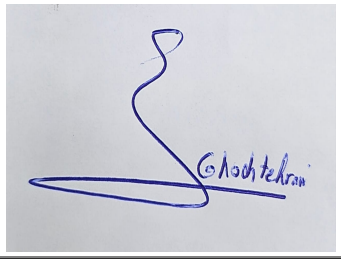
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Mohammadmahdi **Stamp :**

Patient 's signature{Parent : if minor}

Date : 15-Jan-2024

Signature :



Date : 15-Jan-2024