Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: ARIJ BEN ZINEB**	**Service Date**	**:02-Feb-2024**
Card No	**: I017-029-119290084-01**	**Health Provider**	**:Irham Medical Center Arjan**
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**		

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 : C/O GASTROESOPHAGIAL REFLUX DISEASE EPIGASTRIC PAIN FAMILY HISTORY OF H PYLORI INFECTION **Duration:**

Vitals: Temp : 37.5 Bp :95 Pulse :73 Resp :22

Clinical Findings:

Diagnosis: K29.70 - Gastritis, unspecified, without bleeding,K21.9 - Gastro-esophageal reflux disease without esophagitis,R14.0 - Abdominal distension (gaseous),K51.90 - Ulcerative colitis, unspecified, without complications,B96.81 - Helicobacter pylori as the cause of diseases classd elswhr, **Date of Onset** :02/00/2024

Requested Investigations: 9, Consultation GP,0005-242802-0781, PANTONIX 40MG I.V.-(PANTOPRAZOLE (AS SODIUM) : 40 MG) POWDER FOR INFUSION,96365, THER/PROPH/DIAG IV INF INIT,0005-150403-1021, PREMOSAN -(METOCLOPRAMIDE : 10 MG/2ML) SOLUTION FOR INJECTION,86677, ANTIBODY HELICOBACTER PYLORI,82947, GLUCOSE QUANTITATIVE BLOOD XCPT REAGENT STRIP,86140, C REACTIVE PROTEIN,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT **Estimated Cost** :

Prescriptions: 0097-397801-0391 - (DOMPERIDONE (AS MALEATE) : 10 MG) FILM COATED TABLETS,1176-345301-0061 - (MELATONIN : 3 MG) CAPSULES,0155-132303-1451 - (MEBEVERINE : 200 MG) CAPSULES (HARD GELATIN),0430-161101-1172 - (BISMUTH SUBCITRATE : 120 MG) TABLETS,0252-380301-0341 - (*PANTOPRAZOLE (AS SODIUM) : 40 MG) ENTERIC 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}

Date : 02-Feb-2024

Signature :

Date : 02-Feb-2024