Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: TADIOUS FIKRE GEBREMIKAEL**	**Service Date**	**:12-Feb-2024**	**Network**	**:** Green
Card No	**: I017-029-116122365-02**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	**: TADIOUS FIKRE GEBREMIKAEL**	**Doctor's Name**	**:Sajid Sanaullah**		
Payer Name	**: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:		
TPA	**: E CARE - Green Network**	**Remarks**	**:**		
Validity	**: 01-10-2023** To **30-09-2024**				
Gender	**: Male**				
Date Of Birth	**: 23-Sep-1991**				
Patient's Tel No	**: 0501340747**				

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 PAIN IN STOMACH AND HEAVY FEELING IN ABDOMEN ON ASSESMENT PT HAS DISTENDED ABDOMEN AND SEEMS GENERALLY UNWELL **Duration:**

Vitals: Temp : 36.6 Bp :128 Pulse :80 Resp :22

Clinical Findings:

Diagnosis: R10.13 - Epigastric pain,K29.00 - Acute gastritis without bleeding,R10.9 - Unspecified abdominal pain, **Date of Onset:**12/30/2024

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86141, C TO REACTIVE PROTEIN HIGH SENSITIVITY,85651, SEDIMENTATION RATE RBC NON AUTOMATED,82947, GLUCOSE QUANTITATIVE BLOOD XCPT REAGENT STRIP,0005-242802-0781, PANTONIX 40MG I.V.-(PANTOPRAZOLE (AS SODIUM) : 40 MG) POWDER FOR INFUSION,96374, THER/PROPH/DIAG INJ IV PUSH,0005-150403-1021, PREMOSAN -(METOCLOPRAMIDE : 10 MG/2ML) SOLUTION FOR INJECTION,0005-136504-1021, SCOPINAL-(HYOSCINE : 20 MG/ML) SOLUTION FOR INJECTION,9, Consultation GP **Estimated Cost :**

Prescriptions: 0042-136501-1171 - (HYOSCINE : 10 MG) TABLETS,0097-397801-0391 - (DOMPERIDONE (AS MALEATE) : 10 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 :**

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

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

Signature :  **Date** : 12-Feb-2024