Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: ARIJ BEN ZINEB**	**Service Date**	**:07-Mar-2024**
Card No	**: I017-029-119290084-01**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	**: ARIJ BEN ZINEB**	**Doctor's Name**	**:Mohammadbagher**
Payer Name	**: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	**:**
TPA	**: E CARE - Blue Network**	**Remarks**	**:**
Validity	**: 12-04-2023** 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 : a lady come here complain from dyspaghia plan of care endoscopy **Duration :**

Vitals:

Clinical Findings:

Diagnosis: K21.9 - Gastro-esophageal reflux disease without esophagitis, **Date of Onset** :07/43/2024

Requested Investigations: 10, Consultation Specialist **Estimated Cost :**

Prescriptions: **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 : Mohammadbagher **Stamp :**

Signature :

Date : 07-Mar-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 : 07-Mar-2024