AMERICAN MISSION HOSPITAL S.P.C

Bldg: 133, Road: 365, Block: 307, Manama, Kingdom of Bahrain, P.O.Box 1. Tel: 17177711 Fax: 17234194 www.amh.org.bh

TAX INVOICE / RECEIPT

MR No	: 552937 Medtrak No : 553787	TPA	: Health360
Patient	: DEEBA SHAMIM JAIRAJPURI	Insurance	: TAZUR COMPANY B.S.C.CLOSED
Age	: 40 Year(s) Old	Scheme	: ArabianGulfUniversity-A-OPD-Co20%
Doctor	: Kenneth Joseph (INTERNAL MEDICINE)	Branch	: Manama
Visit	: 1456969 (03/Nov/2020 01:56 PM)	PIC Add	: Bldg.: Mandarine Business Centre, 3rd Floor, Suite 35, Seef District, Manama, Kingdom of Bahrain, P. O. Box 65394
AMH VAT No	: 200000807400002	PIC VAT No	: 200000513800002

CPT Code	Description	Qty	VAT (%)	Price	Total	Ins Amt	VAT (I)	Pat Amt	VAT (P)
99210	Consult Est Pt	1	0 %	0.000	0.000	0.000	0.000	0.000	0.000
T0241	Tryptizol 10mg Tab(Amitriptyline)	14	0 %	0.025	0.350	0.000	0.000	0.350	0.000
T0566	Takepron 30Mg Capsule	28	0 %	0.644	18.032	14.426	0.000	3.606	0.000
T0908	Lioresal 10mg Tablet	28	0 %	0.110	3.080	2.464	0.000	0.616	0.000

Total Amt:	**21.462**	**16.890**	**4.572**
VAT Amt:	**0.000**	**0.000**	**0.000**
Gross Amt:	**21.462**	**16.890**	**4.572**
Net Amt:		**16.890**	

Printed by : Steven M. D Souza (2589) 07-Dec-2020 03:20 PM

American Mission Hospital - Insurance Claim Form /Lab/X-Ray/Other:

Name	: **DEEBA SHAMIM JAIRAJPURI**	DOB	: 29/Mar/1980
MR No.	: 552937	MedTrak MRNo.	: 553787
Visit No.	: 1456969	CPR	: 800373391
Age	: 40 Year(s) 7 Month(s) 5 Day(s) Old	Visit Dt.	: 03-Nov-2020 01:56 PM
Gender	: FEMALE	Nationality	: INDIA
Doctor	: **Kenneth Joseph (1726)**	Phone No.	: 33246747
Department	: INTERNAL MEDICINE	Insurance Type	: TAZUR COMPANY B.S.C.CLOSED
Branch	: Manama	Expiry Date	: 21-Dec-2020

Allergy

NKDA

Liya Paul 18-Feb-2017

New Case - Visit No. : 1456969 Visit Date : 03-Nov-2020 01:56 PM Doctor : Kenneth Joseph

SUBJECTIVE

Chief Complaints/ Main Symptoms

patient has come for follow-up visit; noted burning sensation in the epigastric area and mid lower chest; given Tryptizol and her barium swallow GERD

OBJECTIVE

Vital Signs

Height (cm)	Weight (kg)	Temp (°C)	Pulse	BP Sys	BP Dias	Head Circum (cm)	Blood Sugar	BMI	RESP (rpm)	SPO2 (%)
166	95	-	-	-	-	-	-	34.48	-	

Blood / Urinalysis

NONE

ASSESSMENT

GERD with Neuropathy

Orders

RUS	Code	Description	Qty	Comment	User	Ordered By	Ordered Date
Routine	99210	Consult Est Pt	1	-	Kenneth Joseph	Kenneth Joseph	03-Nov-2020 02:09 PM

Diagnosis

K21	**Gastro-oesophageal reflux disease**	**Kenneth Joseph**	**03-Nov-2020**
G90.0	**Idiopathic peripheral autonomic neuropathy**	**Kenneth Joseph**	**03-Nov-2020**

PLANNING

advised

Medication

RUS	Code	Description	Dose	Frequency	Days	Qty	Route	Spl. Inst	Comment	User	Ordered By	Ordered Date
Routine	T0241	Tryptizol 10mg Tab(Amitriptyline)	1 tab	Once a day	14	14	By Mouth	After Dinner		Kenneth Joseph	Kenneth Joseph	03-Nov-2020 02:23 PM
Routine	T0908	Lioresal 10mg Tablet	1 tab	2 times a day	14	28	By Mouth	Before Meals		Kenneth Joseph	Kenneth Joseph	03-Nov-2020 02:23 PM
Routine	T0566	Takepron 30Mg Capsule	1 Cap	2 times a day	14	28	By Mouth	1/2 hour before meals		Kenneth Joseph	Kenneth Joseph	03-Nov-2020 02:23 PM

(Dr. Kenneth Joseph - Internist/Gastroenterologist)

Universal Claim Form

Provider Name:	**American Mission Hospital**		
Insurance Co.:	**TAZUR COMPANY B.S.C.CLOSED**		
TPA Name:	**Health360**		
Patient File No:	**552937**	Dept:	INTERNAL MEDICINE

☐ Single ☐ Married

☑ New Visit ☐ Follow Up Date of Visit: 03/11/2020

DEEBA SHAMIM JAIRAJPURI **552937**

DOB : 03/29/1980 Age : 40 Yrs. Nat : INDIA Sex : **F**

Tel Work : Mobile : 33246747

Bld : 390, Flat : 41, Rd :1210, Blk :312

MANAMA / ALGUFUL

Insurance Plan : ArabianGulfUniversity-A-OPD-Co20%

Membership No : 800373391 Policy no : BAH/GR/19/79

Visit Date : 03/11/2020 Expiry Date : 21/12/2020

☐ Inpatient ☑ Outpatient ☐ Day Care Emergency Case ☐ Yes ☑ No

BP: Pulse: Temp: BMI: **34.48** Duration of condition:

First Visit with this diagnosis Date: Visit No: Doctor:

Chief Complaint & Main Symptoms:

patient has come for follow-up visit; noted burning sensation in the epigastric area and mid lower chest; given Tryptizol and her barium swallow GERD

Significant Details:

abd: unremarkable

ICD10

K21 Gastro-oesophageal reflux disease

G90.0 Idiopathic peripheral autonomic neuropathy

Case Type

☐ Chronic ☐ Congenital ☐ PreExisting ☐ RTA ☐ Work Related ☐ Vaccination

☐ Check-Up ☐ Psychiatric ☐ Infertility ☐ Pregnancy / Indicate LMP:

Suggestive line(s) of management: Kindly, enumerate the recommended investigations, and/or procedures for Outpatient approvals only:

Code	Description/Service	Quantity	Type	Cost
			Total	

Please specify possible line of management when applicable:

advised

Justification:

Estimated Length of Stay: _____ days Expected Date of Admission: _____

I hereby certify that ALL information mentioned are correct and that the medical services shown on this form were medically indicated and necessary for the management of this case.

Physician Signature & Stamp:

Kenneth Joseph

Date: 03/11/2020 Dept: INTERNAL MEDICINE

I the undersigned hereby certify that all statements and information provided concerning identification and the present illness or injury are true. Further I authorize and request the Hospital to provide Insurer/TPA with any information they request in connection with any treatment and/or services provided to me in this visit and grant them full access to my medical records. The receipt of this claim form/other supporting/related documents does not constitute or be deemed to constitute an agreement by the company of the claim and the company reserves the right to process or reject or require furture/additional information in respect of the claim.

Name & Relationship (if guardian) Signature Date: 03/11/2020

** Provider's Approval / Coding Staff must review / code the recommended service (s) & allocate cost and complete the following:*
Total Cost: ..... As estimated / Package Deal

Completed / Coded by: .....Signature.....Date:.....

For Insurance Company Use Only ☐ **Approved** ☐ **Not Approved** **Approval No.: .....**

Comments: (include approved days / services, if different from the required) **Approval Validity .....**

.....
.....
.....

Insurance Officer: _____ **Signature:** _____ **Date:** _____