Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **RAKESH RAWAT KUWAR SINGH**	**Service Date**	**:26-Jun-2024** **Network** : Green
Card No	: **I017-029-114504361-02**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **RAKESH RAWAT KUWAR SINGH**	**Doctor's Name**	**:Humaira**
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	: **10-May-1993**		
Patient's Tel No	: **0569096867**		

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 : co pain in throat dryness of the mouth fever on and off epigastric pain 23 june 2024 oe enlarge and inflamed tonsills chest is clear no added sounds restless taking tablet paracetamol at home **Duration:**

Vitals: Temp : 36.9 Bp :91 Pulse :43 Resp :18

Clinical Findings:

Diagnosis: R50.9 - Fever, unspecified,J03.90 - Acute tonsillitis, unspecified,E86.0 - Dehydration,R10.13 - Epigastric pain, **Date of Onset** :26/51/2024

Requested Investigations: 9.01, Follow Up Consultation GP,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,85652, SEDIMENTATION RATE RBC AUTOMATED,0195-107704-0801, CEFTRIAXONE-TABUK IV,0102-100104-1001, SODIUM CHLORIDE & DEXTROSE B.P.,96365, THER/PROPH/DIAG IV INF INIT,96360, HYDRATION IV INFUSION INIT **Estimated Cost** :

Prescriptions: 6445-533801-1561 - (ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) DELAYED RELEASE CAPSULES,0005-107001-0051 - (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,0139-116206-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) 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.

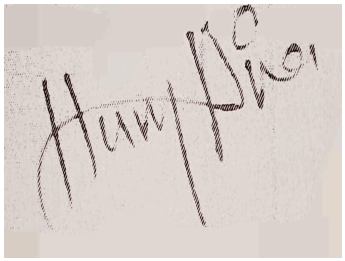
PATIENT'S DECLARATION :

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 : Humaira **Stamp :**

Dr. Humaira Mumtaz
General Practitioner
DHA No: 54155530-002
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

Patient 's signature{Parent if minor} : **Date :** 26-Jun-2024

Signature :  **Date** : 26-Jun-2024