Administrative **MEDICAL CLAIM FORM** **Claim Ref:**

Patient Name	: **JAREESH DOMINIC REJI DOMINIC**	**Service Date**	:**26-Jun-2024** **Network** : Green
Card No	: **I017-029-118146571-02**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **JAREESH DOMINIC REJI DOMINIC**	**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	: **12-Apr-1999**		
Patient's Tel No	: **0545718087**		

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 the neck fever on and off 23 june 2024 oe enlarge and inflamed tonsills protubernt eyes ill looking chest is congested no added sound restless **Duration:**

Vitals: Temp : 36.5 Bp :120 Pulse :70 Resp :18

Clinical Findings:

Diagnosis: R50.9 - Fever, unspecified,J03.90 - Acute tonsillitis, unspecified,R52 - Pain, unspecified,E05.90 - Thyrotoxicosis, unsp without thyrotoxic crisis or storm, **Date of Onset** :26/39/2024

Requested Investigations: 9, CONSULTATION GP,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,85652, SEDIMENTATION RATE RBC AUTOMATED,84436, THYROXINE TOTAL,84443, THYROID STIMULATING HORMONE TSH,84479, THYROID HORM UPTK/THYROID HORMONE BINDING RATIO,0195-107704-0801, CEFTRIAXONE-TABUK IV,96365, THER/PROPH/DIAG IV INF INIT,9, Consultation GP **Estimated Cost** :

Prescriptions: 0005-107001-0051 - (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS,0195-116604-0391 - (METRONIDAZOLE : 500 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

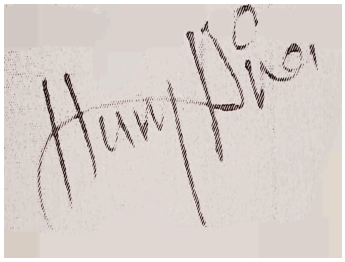
Stamp :

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