Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: PRINCE AMAR SINGH**	**Service Date**	**:27-Jun-2024**	**Network**	**:** Green
Card No	**: I017-029-118921925-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**		**Direct Access SP - YES**
Policy Holder	**: PRINCE AMAR SINGH**	**Doctor's Name**	**:Humaira**		
Payer Name	**: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:		

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

TPA : **E CARE - Green Network**
Validity : **01-10-2023** To **30-09-2024**
Gender : **Male**
Date Of Birth : **07-Dec-1992**
Patient's Tel No : **0569488659**
Remarks :

☐ **Acute** ☐ **Pre-existing and chronic** ☐ **Maternity**

Chief Complaints : co fever on and off vomitting 4 episode diarrhea 5 episode 20 june 2024 oe chest is clear no added sounds restless dehydrated having chohla bahtora **Duration:**

Vitals: Temp : 36.7 Bp :115 Pulse :82 Resp :18

Clinical Findings:

Diagnosis: R50.9 - Fever, unspecified,R19.7 - Diarrhea, unspecified,R11.10 - Vomiting, unspecified,R10.9 - Unspecified abdominal pain, **Date of Onset** :27/11/2024

Requested Investigations: 9, Consultation GP,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,85652, SEDIMENTATION RATE RBC AUTOMATED,86140, C REACTIVE PROTEIN,0195-107704-0801, CEFTRIAXONE-TABUK IV,0102-100104-1001, SODIUM CHLORIDE & DEXTROSE B.P.,0005-150403-1021, PREMOSAN -(METOCLOPRAMIDE : 10 MG/2ML) SOLUTION FOR INJECTION,0005-242802-0781, PANTONIX 40MG I.V.,96365, THER/PROPH/DIAG IV INF INIT,96374, THER/PROPH/DIAG INJ IV PUSH **Estimated Cost** :

Prescriptions: 0097-397801-0391 - (DOMPERIDONE (AS MALEATE) : 10 MG) FILM COATED TABLETS,0005-107001-0051 - (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS,0097-230603-0831 - (ORAL REHYDRATION SALTS (O.R.S.) : N/A) POWDER FOR SOLUTION,0219-142902-1451 - (CEFIXIME : 400 MG) CAPSULES (HARD GELATIN),0195-116604-0391 - (METRONIDAZOLE : 500 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 : Humaira

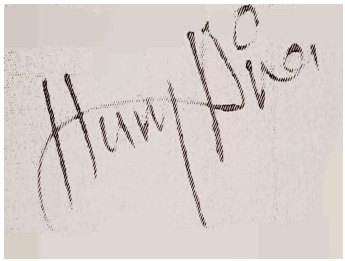
Stamp :

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

Patient 's signature{Parent if minor} :

Date : 27-Jun-2024

Signature :



Date : 27-Jun-2024