

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name

:

HIRUSHA BATHIYA
RATNAYAKA

Card No

:

I017-029-119293725-01

Policy Holder

:

HIRUSHA BATHIYA
RATNAYAKA

Payer Name

:

ABU DHABI NATIONAL
INSURANCE COMPANY-
ADNIC

TPA

:

E CARE - Green Network

Validity

:

01-10-2023 To 30-09-2024

Gender

:

Male

Date Of Birth

:

03-Dec-2001

Patient's Tel No

:

971566442706

Service Date

:

27-Jun-2024

Health Provider

:

CITICARE MEDICAL CENTER LLC

Doctor's Name

:

Humaira

Co-Insurance

:

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

Network

:

Green

Direct Access SP

:

YES

Remarks :

☐ Acute

☐ Pre-existing and chronic

☐ Maternity

Chief Complaints

:

co fever cough prulent running nose 23 june 2024 oe chest is congested no added sounds restless smoker

Vitals

:

Temp : 38.5 Bp :107 Pulse :88 Resp :18

Clinical Findings:

Diagnosis:

R50.9 - Fever, unspecified,J06.9 - Acute upper respiratory infection, unspecified,R05 - Cough,R52 - Pain, unspecified,J30.9 - Allergic rhinitis, unspecified,

Date of Onset

:

27/11/2024

Requested Investigations:

85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,85652, SEDIMENTATION RATE RBC AUTOMATED,0195-107704-0801, CEFTRIAXONE-TABUK IV,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,96372, THER/PROPH/DIAG INJ SC/IM,96365, THER/PROPH/DIAG IV INF INIT,9, Consultation GP

Estimated : Cost

Prescriptions:

0097-393801-2471 - (AMMONIUM CHLORIDE : 131.5 MG/5 ML) (DIPHENHYDRAMINE HCL : 13.5 MG/5ML) SYRUP (ALCOHOL FREE),0195-116604-0391 - (METRONIDAZOLE : 500 MG) FILM COATED TABLETS,0333-143602-1171 - (CEFUROXIME : 500 MG) TABLETS,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,0005-107001-0051 - (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS,

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

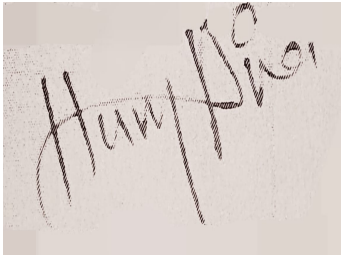
:

Humaira

Stamp :

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

Signature :

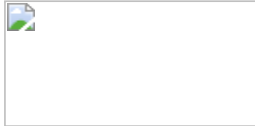


Date

:

27-Jun-2024

Patient 's signature{Parent : if minor}



Date

:

27-Jun-2024