

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name

: Sujith Dias Walawe Gamage

Card No

: I017-029-114504431-02

Policy Holder

: Sujith Dias Walawe Gamage

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

: 04-Mar-1992

Patient's Tel No

: 0564998297

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

☐ Acute

☐ Pre-existing and chronic

☐ Maternity

Chief Complaints

: co fever running nose cough dry bodyache 22 june 2024 oe chest is congested no added sounds restless

Duration:

Vitals

:Temp : 38 Bp :102 Pulse :73 Resp :18

Clinical Findings:

Diagnosis

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

Date of Onset

:27/14/2024

Requested Investigations

: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,85652, SEDIMENTATION RATE RBC AUTOMATED,86140, C REACTIVE PROTEIN,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,0195-107704-0801, CEFTRIAXONE-TABUK IV,96365, THER/PROPH/DIAG IV INF INIT,96372, THER/PROPH/DIAG INJ SC/IM,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),0005-107001-0051 - (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS,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,

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