Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **SHEHAN BANUKA JAYAWARDANA MUDALIGE**	**Service Date**	**:02-Jul-2024**
Card No	: **I017-029-119215065-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**
Policy Holder	: **SHEHAN BANUKA JAYAWARDANA MUDALIGE**	**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	: **06-Jun-1996**		
Patient's Tel No	: **971566442706**		

Network : Green

Direct Access SP - YES

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 cough prulant fever on and off body ache 26 june 2024 oe enlarge and inflamed chest is wheezing no added sounds restless **Duration:**

Vitals: Temp : 37.2 Bp :120 Pulse :92 Resp :18

Clinical Findings:

Diagnosis: R50.2 - Drug induced fever,J06.9 - Acute upper respiratory infection, unspecified,R05 - Cough,K29.70 - Gastritis, unspecified, without bleeding, **Date of Onset** :02/44/2024

Requested Investigations: 9, Consultation GP,INJ018, INJ-HYDROCORTISONE 500MG/4ML ,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,85652, SEDIMENTATION RATE RBC AUTOMATED,86140, C REACTIVE PROTEIN,0195-107704-0801, CEFTRIAXONE-TABUK IV,96365, THER/PROPH/DIAG IV INF INIT,0188-135906-2441, PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION,94640, AIRWAY INHALATION TREATMENT,96365, THER/PROPH/DIAG IV INF INIT,96365, THER/PROPH/DIAG IV INF INIT **Estimated Cost** :

Prescriptions: 0207-169703-1161 - (AMMONIUM CHLORIDE : N/A) (DIPHENHYDRAMINE : N/A) SYRUP,0005-107001-0052 - (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS,0005-119803-1171 - (PREDNISOLONE : 20 MG) TABLETS,0195-116604-0391 - (METRONIDAZOLE : 500 MG) FILM COATED TABLETS,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,0333-143602-1171 - (CEFUROXIME : 500 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

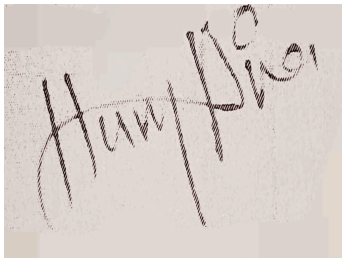
Stamp :

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

Patient 's signature{Parent if minor} :

Date : 02-Jul-2024

Signature :



Date : 02-Jul-2024