Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **RAJASEKAR BOOPATHI BOOPATHI VATHALAN**	**Service Date**	**:03-Jul-2024**	**Network**	: Green
Card No	: **I017-029-120836722-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**	**Direct Access SP - YES**	
Policy Holder	: **RAJASEKAR BOOPATHI BOOPATHI VATHALAN**	**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 **01-10-2023**				
Gender	: **Male**				
Date Of Birth	: **12-Jun-1991**				
Patient's Tel No	: **0527053722**				

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 watery diarrhea fever on and off cough running nose 23 june 2024 loosing **Duration:**
weight at least 12 kg wiith in 3 momths oe enlarge tonsills chest is congested no added sounds
restless

Vitals: Temp : 37.2 Bp :135 Pulse :53 Resp :18

Clinical Findings:

Diagnosis: R50.9 - Fever, unspecified,R19.7 - Diarrhea, unspecified,R63.4 - Abnormal weight loss,R05 - Cough, **Date of Onset :** 03/51/2024

Requested Investigations: 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,0002-116601-1001, METRONIDAZOLE : 500 MG/100ML) SOLUTION FOR INFUSION ,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,3114-482003-0391 - (CIPROFLOXACIN (AS HYDROCHLORIDE) : 500 MG) FILM COATED TABLETS, **Estimated Cost :**

MEDICAL PRACTITIONER DECLARATION : **PATIENT'S 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.

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.

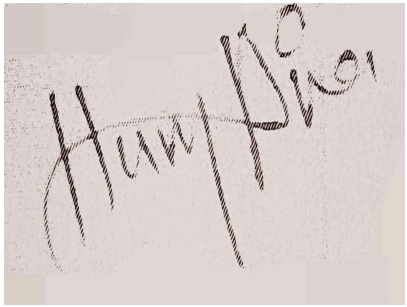
Dr's Name : Humaira

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 : 03-Jul-2024

Signature : 

Date : 03-Jul-2024