Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: John Viannie Kajoba**	**Service Date**	**:03-Jul-2024**	**Network**	**:** Green
Card No	**: I017-029-114165333-02**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**		**Direct Access SP - YES**
Policy Holder	**: John Viannie Kajoba**	**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	**: 05-Jul-1992**				
Patient's Tel No	**: 0522262866**				

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 fever bodyache 30 june 2024 oe enlarge and inflamed tonsills chest is clear no added sounds restless **Duration:**

Vitals: Temp : 39.5 Bp :120 Pulse :95 Resp :18

Clinical Findings:

Diagnosis: R50.9 - Fever, unspecified,J03.90 - Acute tonsillitis, unspecified,R52 - Pain, unspecified, **Date of Onset :**03/37/2024

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,85652, SEDIMENTATION RATE RBC AUTOMATED,86140, C REACTIVE PROTEIN,2190-106618-1001, PARAFUSIV,0005-149902-1021, CLOFEN ,0195-107704-0801, CEFTRIAXONE-TABUK IV-(CEFTRIAXONE : 1 G) POWDER FOR INJECTION,96365, THER/PROPH/DIAG IV INF INIT,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP,96374, THER/PROPH/DIAG INJ IV PUSH,0095-149911-1021, OLFEN,0195-107704-0801, CEFTRIAXONE-TABUK IV,2040-106618-1001, PARACETAMOL S.A.L.F (PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION **Estimated Cost :**

Prescriptions: 0027-142201-0831 - (DICLOFENAC POTASSIUM : 50 MG) POWDER FOR SOLUTION,0195-116604-0391 - (METRONIDAZOLE : 500 MG) FILM COATED TABLETS,0333-143602-1171 - (CEFUROXIME : 500 MG) 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.

Patient 's signature{Parent if minor} : **Date :** 03-Jul-2024

Signature : **Date :** 03-Jul-2024