Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **THARINDU UDAYANGA DE SILVA SIVANETHTHI**	**Service Date**	**:06-Jul-2024**	**Network**	: Green
Card No	: **I017-029-120104390-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**	**Direct Access SP - YES**	
Policy Holder	: **THARINDU UDAYANGA DE SILVA SIVANETHTHI**	**Doctor's Name**	**:Enomen Goodluck**		
Payer Name	: **ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:		
TPA	: **E CARE - Green Network**	**Remarks**	:		
Validity	: **20-11-2023** To **30-09-2024**				
Gender	: **Male**				
Date Of Birth	: **15-Jul-1997**				
Patient's Tel No	: **0528644092**				

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 : PC: High grade fever, generalized body pains, vomiting, abdominal pain, and diarrhea of over 30 episodes in the past 3 days. Duration of fever: 3days. Abdominal pain is located in the lower abdomen and is colicky in nature, and is relieved following defecation, only to return hours later. **Duration:**

Vitals:

Clinical Findings:

Diagnosis: A09 - Infectious gastroenteritis and colitis, unspecified,R10.30 - Lower abdominal pain, unspecified,R19.7 - Diarrhea, unspecified,R50.9 - Fever, unspecified,E86.0 - Dehydration, **Date of Onset** :06/48/2024

Requested Investigations: 96360, HYDRATION IV INFUSION INIT,0102-152902-1001, LACTATED RINGERS INJECTION USP,0005-136504-1021, SCOPINAL,2190-106618-1001, PARAFUSIV,0005-149902-1021, CLOFEN ,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,0005-242802-0781, PANTONIX 40MG I.V.,96372, THER/PROPH/DIAG INJ SC/IM,87046, CUL BACT STOOL AEROBIC ADDL PATHOGENS&ID EA,9, Consultation GP **Estimated Cost** :

Prescriptions: 0042-136501-1173 - (HYOSCINE : 10 MG) TABLETS,0137-242802-0342 - (PANTOPRAZOLE (AS SODIUM) : 40 MG) ENTERIC COATED TABLETS,0067-116604-0391 - (METRONIDAZOLE : 500 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 : Enomen Goodluck **Stamp :**

Dr. Enomen Goodluck Ekata
General Practitioner
DHA No: 28040827-001
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

Patient 's signature{Parent if minor} : **Date :** 06-Jul-2024

Signature : **Date** : 06-Jul-2024