

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name

: THARINDU UDAYANGA DE SILVA SIVANETHTHI

Card No

: I017-029-120104390-01

Policy Holder

: THARINDU UDAYANGA DE SILVA SIVANETHTHI

Payer Name

: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC

TPA

: E CARE - Green Network

Validity

: 20-11-2023 To 30-09-2024

Gender

: Male

Date Of Birth

: 15-Jul-1997

Patient's Tel No

: 0528644092

Service Date

: 06-Jul-2024

Health Provider

: CITICARE MEDICAL CENTER LLC

Doctor's Name

: Enomen Goodluck

Co-Insurance

Remarks

:

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

: 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.

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

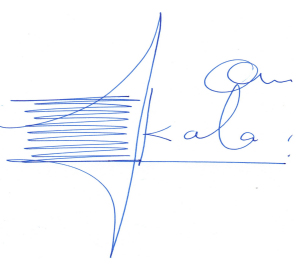
General Practitioner

DHA No: 28040827-001

CITICARE MEDICAL CENTER LLC

DUBAI - U.A.E.

Signature :



Date

: 06-Jul-2024

Patient 's signature{Parent : if minor}



Date

: 06-Jul-2024