Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **RUPESH THAPA**	**Service Date**	:**07-Jul-2024**	**Network**	: Green
Card No	: **I017-029-114504371-02**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC**		**Direct Access SP - YES**
Policy Holder	: **RUPESH THAPA**	**Doctor's Name**	:**Humaira**		
Payer Name	: **ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

TPA	: **E CARE - Green Network**	**Remarks**	:
Validity	: **01-10-2023** To **30-09-2024**		
Gender	: **Male**		
Date Of Birth	: **06-Jan-1996**		
Patient's Tel No	: **0561758415**		

☐ **Acute** ☐ **Pre-existing and chronic** ☐ **Maternity**

Chief Complaints : co fever on and off running nose sneezing dark colour urine pain in urination **Duration:**
3rd july 2024 oe enlarge tonsills chest is congested no added sounds restless

Vitals: Temp : 36.9 Bp :119 Pulse :66 Resp :18

Clinical Findings:

Diagnosis: R50.9 - Fever, unspecified,J30.9 - Allergic rhinitis, unspecified,J06.9 - Acute upper respiratory infection, unspecified,N39.0 - Urinary tract infection, site not specified,R30.9 - Painful micturition, unspecified, **Date of Onset** :07/52/2024

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,85652, SEDIMENTATION RATE RBC AUTOMATED,81001, URNLS DIP STICK/TABLET REAGENT AUTO MICROSCOPY,0195-107704-0801, CEFTRIAXONE-TABUK IV,96365, THER/PROPH/DIAG IV INF INIT,9, Consultation GP **Estimated Cost** :

Prescriptions: 0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,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

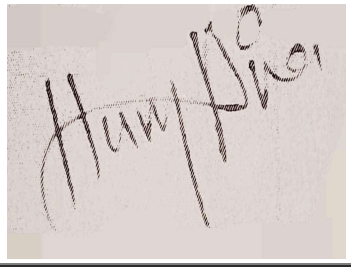
Stamp :

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

Patient 's signature{Parent if minor} :

Date : 07-Jul-2024

Signature :



Date : 07-Jul-2024