Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: NISHANTHA BANDARANAYAKA MUDIYANSELAGE**
Card No	**: I017-029-116122149-02**
Policy Holder	**: NISHANTHA BANDARANAYAKA MUDIYANSELAGE**
Payer Name	**: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**
TPA	**: E CARE - Green Network**
Validity	**: 01-10-2023** To **30-09-2024**
Gender	**: Male**
Date Of Birth	**: 22-Nov-1989**
Patient's Tel No	**: 0528867477**

Service Date **:19-Jul-2024** **Network** **:** Green

Health Provider **:CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**

Doctor's Name **:Humaira**

Co-Insurance :

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

Remarks :

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

Chief Complaints : co ear pain and itching remove something from the ear with spoon now he feels ear is blocked and pain left side oe in the ear thereis is redness and small strach membrane is intact chest is clear no addded sounds restless **Duration:**

Vitals: Temp : 37.1 Bp :119 Pulse :62 Resp :18

Clinical Findings:

Diagnosis: H66.92 - Otitis media, unspecified, left ear,S00.412A - Abrasion of left ear, initial encounter,R52 - Pain, unspecified, **Date of Onset** **:**19/40/2024

Requested Investigations: 9, Consultation GP **Estimated Cost** :

Prescriptions: 0027-142201-0832 - (DICLOFENAC POTASSIUM : 50 MG) POWDER FOR SOLUTION,0333-143602-1171 - (CEFUROXIME : 500 MG) TABLETS,0609-280801-0241 - PHENAZONE, **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.

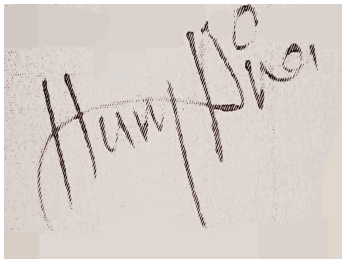
PATIENT'S DECLARATION :

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 :** 19-Jul-2024

Signature :  **Date** : 19-Jul-2024