Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: ANDREW SSENGENDO**	**Service Date**	**:23-Jul-2024**
Card No	**: I017-029-120944260-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**
Policy Holder	**: ANDREW SSENGENDO**	**Doctor's Name**	**:Humaira**
Payer Name	**: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	**:**
TPA	**: E CARE - Green Network**	**Remarks**	**:**
Validity	**: 19-06-2024** To **30-09-2024**		
Gender	**: Male**		
Date Of Birth	**: 17-Apr-1997**		
Patient's Tel No	**: 05094927312**		

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 : **Duration :**

Vitals:

Clinical Findings:

Diagnosis: R50.9 - Fever, unspecified,J03.90 - Acute tonsillitis, unspecified,R52 - Pain, unspecified,K29.00 - Acute gastritis without bleeding,N39.0 - Urinary tract infection, site not specified, **Date of Onset** **:**23/36/2024

Requested Investigations: 9.01, Follow Up Consultation GP,82947, GLUCOSE QUANTITATIVE BLOOD XCPT REAGENT STRIP,0195-107704-0801, CEFTRIAXONE-TABUK IV,96365, THER/PROPH/DIAG IV INF INIT **Estimated Cost** **:**

Prescriptions: **Estimated Cost** **:**

MEDICAL PRACTITIONER DECLARATION :

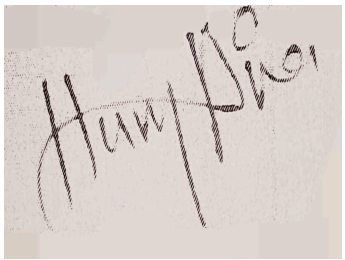
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

Dr's Name : Humaira

Stamp :

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

Signature :



Date : 23-Jul-2024

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.

Patient 's signature{Parent if minor} :

Date : 23-Jul-2024