Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: SWAROOP KORTI**	**Service Date**	**:24-Jul-2024**	**Network**	**: Green**
Card No	**: I017-029-120763030-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**		**Direct Access SP - YES**
Policy Holder	**: SWAROOP KORTI**	**Doctor's Name**	**:Enomen Goodluck**		
Payer Name	**: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:		
TPA	**: E CARE - Green Network**	**Remarks**	:		
Validity	**: 01-10-2023** To **30-09-2024**				
Gender	**: Male**				
Date Of Birth	**: 17-Jun-2000**				
Patient's Tel No	**: 0589418984**				

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: EAR PAIN 1 DAY FEVER 1 DAY COLD SORETHROAT 1 DAY HEADACHE **Duration :**

Vitals: Temp : 37.8 Bp :122 Pulse :81 Resp :18

Clinical Findings:

Diagnosis: A75.9 - Typhus fever, unspecified,J06.9 - Acute upper respiratory infection, unspecified,J00 - Acute nasopharyngitis [common cold],R52 - Pain, unspecified, **Date of Onset** :24/12/2024

Requested Investigations: 0195-107704-0801, CEFTRIAXONE-TABUK IV-(CEFTRIAXONE : 1 G) POWDER FOR INJECTION,0005-149902-1021, CLOFEN ,96365, THER/PROPH/DIAG IV INF INIT,96372, THER/PROPH/DIAG INJ SC/IM,85009, BLOOD COUNT MANUAL DIFRNTL WBC COUNT BUFFY COAT,86140, C REACTIVE PROTEIN,87040, CULTURE BACTERIAL BLOOD AEROBIC W/ID ISOLATES,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,9, Consultation GP **Estimated Cost** :

Prescriptions: 0355-171701-0241 - (BENZOCAINE : N/A) (PHENAZONE : N/A) EAR DROPS,0005-938301-3381 - (CAFFEINE ANHYDROUS : 25 MG) (PARACETAMOL : 500 MG) (PHENYLEPHRINE HCL : 5 MG) CAPLET-TABLET,0195-123701-0391 - CETIRIZINE HCL,0139-116206-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) 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** : 24-Jul-2024

Signature : **Date** : 24-Jul-2024