Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: SANIA RASHEED**	**Service Date**	**:02-Aug-2024**
Card No	**: I017-029-120848630-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**
Policy Holder	**: SANIA RASHEED**	**Doctor's Name**	**:Enomen Goodluck**
Payer Name	**: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:
TPA	**: E CARE - Blue Network**	**Remarks**	:
Validity	**: 24-05-2024** To **30-09-2024**		
Gender	**: Female**		
Date Of Birth	**: 20-Jan-1999**		
Patient's Tel No	**: 0558132736**		

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: Headache, nasal congestion, facial pain, and lower abdominal pain. Periods started today also. There is no fever. **Duration:**

Vitals: Temp : 37.9 Bp :100 Pulse :86 Resp :18

Clinical Findings:

Diagnosis: J03.90 - Acute tonsillitis, unspecified,J01.40 - Acute pansinusitis, unspecified,R51.9 - Headache, unspecified,R50.9 - Fever, unspecified,N94.4 - Primary dysmenorrhea, **Date of Onset** :02/53/2024

Requested Investigations: 96374, THER/PROPH/DIAG INJ IV PUSH,0005-149902-1021, CLOFEN ,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,0195-107704-0801, CEFTRIAXONE-TABUK IV,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,96372, THER/PROPH/DIAG INJ SC/IM,96365, THER/PROPH/DIAG IV INF INIT,9, Consultation GP **Estimated Cost** :

Prescriptions: 0219-142902-1451 - (CEFIXIME : 400 MG) CAPSULES (HARD GELATIN),2027-560101-0392 - (IBUPROFEN : 150 MG) (PARACETAMOL : 500 MG) FILM COATED TABLETS,5253-649501-3851 - (MOMETASONE FUROATE (AS MONOHYDRATE) : 50 MCG/DOSE) NASAL SPRAY,0005-116702-2481 - (DIPHENHYDRAMINE : 12.5 MG/5ML) SYRUP (SUGAR FREE),0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,0252-185801-0391 - (DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 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.

Patient 's signature{Parent : if minor}

Date : 02-Aug-2024

Signature :

Date : 02-Aug-2024