

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : JACKILYN FLORES DE PEDRO
Card No : I017-029-119384579-01
Policy Holder : JACKILYN FLORES DE PEDRO
Payer Name : ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC
TPA : E CARE - Green Network
Validity : 01-10-2023 To 30-09-2024
Gender : Female
Date Of Birth : 19-May-1992
Patient's Tel No : 0544975596

Service Date :05-Aug-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
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Chief Complaints : co headache fever on and off running nose itching inthe throat dry cough **Duration:** 2nd august 2024 oe enlarge and inflamed tonsills chest is congested no added sounds restless taking penadol at 1pm at home

Vitals:Temp : 37 Bp :102 Pulse :64 Resp :18

Clinical Findings:

Diagnosis: R50.9 - Fever, unspecified,J06.9 - Acute upper respiratory infection, unspecified,J03.90 - Acute tonsillitis, unspecified,R05 - Cough,J30.9 - Allergic rhinitis, unspecified, **Date of Onset** :05/16/2024

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,85652, SEDIMENTATION RATE RBC AUTOMATED,86140, C REACTIVE PROTEIN,0195-107704-0801, CEFTRIAXONE-TABUK IV,96365, THER/PROPH/DIAG IV INF INIT,0188-135906-2441, PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION,94640, AIRWAY INHALATION TREATMENT,9, Consultation GP **Estimated : Cost**

Prescriptions: 0097-393801-2471 - (AMMONIUM CHLORIDE : 131.5 MG/5 ML) (DIPHENHYDRAMINE HCL : 13.5 MG/5ML) SYRUP (ALCOHOL FREE),0005-107001-0051 - (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS,0139-116206-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS,0195-123701-0391 - (CETIRIZINE HCL : 10 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.

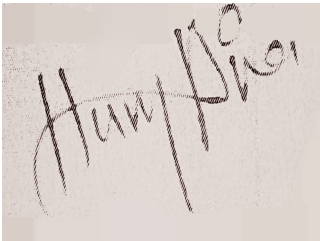
Dr's Name : Humaira

Stamp : 

Patient 's signature{Parent : if minor}



Date : 05-Aug-2024

Signature : 

Date : 05-Aug-2024