Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: AUNG KO KO**	**Service Date**	**:10-Aug-2024**	**Network**	**:** Green
Card No	**: I017-029-119448898-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**	**Direct Access SP - YES**	
Policy Holder	**: AUNG KO KO**	**Doctor's Name**	**:AHSAN HUSSAIN**		
Payer Name	**: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:		
TPA	**: E CARE - Green Network**				
Validity	**: 01-10-2023** To **30-09-2024**				
Gender	**: Male**	**Remarks**	**:**		
Date Of Birth	**: 29-Oct-2000**				
Patient's Tel No	**: 0522642679**				

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: DIZZINESS WEAKNESS **Duration :**

Vitals: Temp : 37 Bp :100 Pulse :86 Resp :18

Clinical Findings:

Diagnosis: M83.9 - Adult osteomalacia, unspecified,M62.81 - Muscle weakness (generalized), **Date of Onset :**10/19/2024

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,82652, 1 25 DIHYDROXY INCLUDES FRACTIONS IF PERFORMED,0102-100104-1001, SODIUM CHLORIDE & DEXTROSE B.P.-(SODIUM CHLORIDE : 0.9%) (DEXTROSE : 5%) SOLUTION FOR INFUSION,96360, HYDRATION IV INFUSION INIT,80051, ELECTROLYTE PANEL,9, Consultation GP **Estimated Cost :**

Estimated Cost :

Prescriptions:

MEDICAL PRACTITIONER DECLARATION :

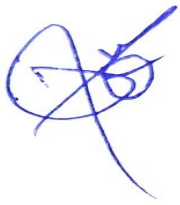
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

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 : AHSAN HUSSAIN **Stamp :**

Patient 's signature{Parent : if minor} **Date :** 10-Aug-2024

Signature :  **Date** : 10-Aug-2024