Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: PRAHLAD SINGH**	**Service Date**	**:15-Aug-2024**
Card No	**: I017-029-119171364-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**
Policy Holder	**: PRAHLAD SINGH**	**Doctor's Name**	**:AHSAN HUSSAIN**
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	**: 06-Apr-1983**		
Patient's Tel No	**: 0506858637**		

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: DIARHEA FEVER ABDOMINAL PAIN **Duration :**

Vitals: Temp : 35.9 Bp :90 Pulse :76 Resp :18

Clinical Findings:

Diagnosis: K29.00 - Acute gastritis without bleeding,R19.7 - Diarrhea, unspecified,R10.9 - Unspecified abdominal pain,A05.9 - Bacterial foodborne intoxication, unspecified, **Date of Onset** :15/25/2024

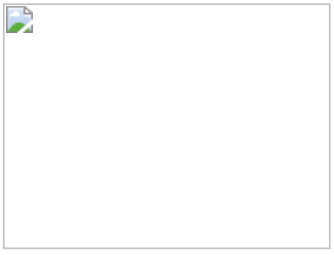
Requested Investigations: 0005-107704-0802, TRIAXONE I.V.-(CEFTRIAXONE : 1 G) POWDER FOR INJECTION,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,0102-100104-1001, SODIUM CHLORIDE & DEXTROSE B.P.-(SODIUM CHLORIDE : 0.9%) (DEXTROSE : 5%) SOLUTION FOR INFUSION,0005-174202-0781, RISEK 40MG,0005-136504-1021, SCOPINAL-(HYOSCINE : 20 MG/ML) SOLUTION FOR INJECTION,96365, THER/PROPH/DIAG IV INF INIT,96372, THER/PROPH/DIAG INJ SC/IM,9.01, Follow Up Consultation GP,96374, THER/PROPH/DIAG INJ IV PUSH **Estimated Cost** :

Prescriptions: **Estimated Cost** :

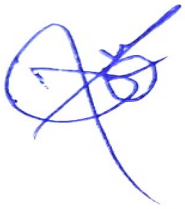
MEDICAL PRACTITIONER DECLARATION :

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 : AHSAN HUSSAIN **Stamp :**



Signature :



Date : 15-Aug-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 : 15-Aug-2024