Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: SHILPA PARIYARATHODI**	**Service Date**	**:15-Aug-2024**
Card No	**: I017-029-120929345-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**
Policy Holder	**: SHILPA PARIYARATHODI**	**Doctor's Name**	**:Humaira**
Payer Name	**: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:
TPA	**: E CARE - Green Network**	**Remarks**	:
Validity	**: 14-06-2024** To **30-09-2024**		
Gender	**: Female**		
Date Of Birth	**: 23-Aug-2024**		
Patient's Tel No	**: 0567310886**		

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 : co dizzyness weakness feeling headache 12th august 2024 oe dehydration chest is clear no added sounds restless **Duration:**

Vitals: Temp : 36.9 Bp :88 Pulse :81 Resp :18

Clinical Findings:

Diagnosis: E86.0 - Dehydration,R51.9 - Headache, unspecified, **Date of Onset** : 15/46/2024

Requested Investigations: 0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,96372, THER/PROPH/DIAG INJ SC/IM,0102-111908-1001, SODIUM CHLORIDE B.P.,96360, HYDRATION IV INFUSION INIT,INJ014, INJ-NEUROBION VITAMIN B GROUPS,80051, ELECTROLYTE PANEL,9, Consultation GP **Estimated Cost** :

Prescriptions: 6792-956301-1171 - (VITAMIN B12 (CYANOCOBALAMIN) : 18 MCG) (VITAMIN D3 (CHOLECALCIFEROL) : 5 MCG) (VITAMIN E : 26.84 MG) (VITAMIN K1 : 25 MCG) (VITAMIN C (ASCORBIC ACID) : 120 MG) (BIOTIN : 40 MCG) (FOLIC ACID : 0.4 MG) (PANTOTHENIC ACID (CALCIUM PANTOTHENATE) : 10 MG) (IODINE (AS POTASSIUM IODIDE) : 0.15 MG) (CALCIUM (AS CARBONATE + CALCIUM PHOSPHATE DIBASIC) : 100 MG) (PHOSPHORUS (AS CALCIUM PHOSPHATE DIBASIC) : 48 MG) (MAGNESIUM(AS MAGNESIUM OXIDE) : 45 MG) (IRON (FERROUS FUMARATE) : 14 MG) (COPPER (AS SULPHATE, **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

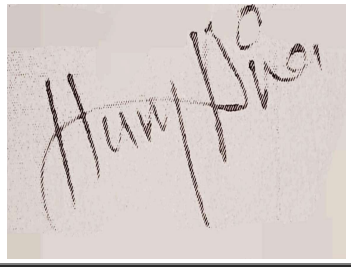
Stamp :

Dr. Humaira Mumtaz
General Practitioner
DHA No: 54155530-002
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

Patient 's signature{Parent if minor} :

Date : 15-Aug-2024

Signature :



Date : 15-Aug-2024