Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **VIRAJ PRAVEERA GARDHI HEWAWASAM**	**Service Date**	**:22-Aug-2024**
Card No	: **I017-029-118236870-02**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**
Policy Holder	: **VIRAJ PRAVEERA GARDHI HEWAWASAM**	**Doctor's Name**	**:Humaira**
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	: **03-Jun-1991**		
Patient's Tel No	: **0524501511**		

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 fever on and off pain in the teeth dark colour of urine and painful urination 18 th august 2024 oe nodule inthe upper jaw painful and inflamed chest is clear no added sounds restless **Duration:**

Vitals: Temp : 37 Bp :156 Pulse :76 Resp :18

Clinical Findings:

Diagnosis: R50.9 - Fever, unspecified,K05.01 - Acute gingivitis, non-plaque induced,R52 - Pain, unspecified,I10 - Essential (primary) hypertension,N39.0 - Urinary tract infection, site not specified, **Date of Onset** :22/36/2024

Requested Investigations: 81001, URNLS DIP STICK/TABLET REAGENT AUTO MICROSCOPY,85652, SEDIMENTATION RATE RBC AUTOMATED,86140, C REACTIVE PROTEIN,0195-107704-0801, CEFTRIAXONE-TABUK IV,96365, THER/PROPH/DIAG IV INF INIT,0005-149902-1021, CLOFEN - (DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,96372, THER/PROPH/DIAG INJ SC/IM,101, GENARAL WELNES CHECKUP (55 TEST),9, Consultation GP **Estimated Cost** :

Prescriptions: 0137-238102-0391 - (OLMESARTAN MEDOXOMIL : 20 MG) FILM COATED TABLETS,0195-116604-0391 - (METRONIDAZOLE : 500 MG) FILM COATED TABLETS,0139-116206-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS,0005-107001-0051 - (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS, **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.

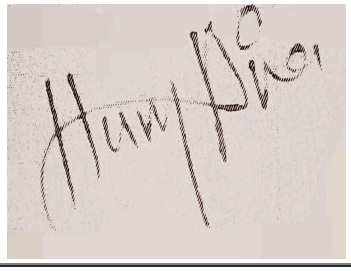
Dr's Name : Humaira

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 : 22-Aug-2024

Signature : 

Date : 22-Aug-2024