Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: JAYA RATAN KAMBLE**	**Service Date**	**:25-Aug-2024**
Card No	**: I017-029-120106903-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**
Policy Holder	**: JAYA RATAN KAMBLE**	**Doctor's Name**	**:AHSAN HUSSAIN**
Payer Name	**: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	**:**
TPA	**: E CARE - Green Network**	**Remarks**	**:**
Validity	**: 18-11-2023** To **30-09-2024**		
Gender	**: Female**		
Date Of Birth	**: 12-May-1984**		
Patient's Tel No	**: 0509398753**		

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 : **Duration :**

Vitals: Temp : 39 Bp :104 Pulse :92 Resp :18

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,J00 - Acute nasopharyngitis [common cold],R51.9 - Headache, unspecified,R10.13 - Epigastric pain, **Date of Onset** :25/20/2024

Requested Investigations: 0005-174202-0781, RISEK 40MG,0195-107704-0801, CEFTRIAXONE-TABUK IV,96365, THER/PROPH/DIAG IV INF INIT,96374, THER/PROPH/DIAG INJ IV PUSH,9.01, Follow Up Consultation GP **Estimated Cost** :

Estimated Cost :

Prescriptions:

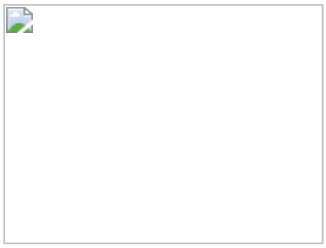
MEDICAL PRACTITIONER DECLARATION :

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.

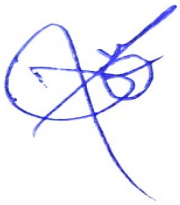
Dr's Name : AHSAN HUSSAIN **Stamp :**



Patient 's signature{Parent if minor} :

Date : 25-Aug-2024

Signature :



Date : 25-Aug-2024