Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: SU SU HTWE**	**Service Date**	**:27-Aug-2024**	**Network**	: Green
Card No	**: I017-029-120181224-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**		**Direct Access SP - YES**
Policy Holder	**: SU SU HTWE**	**Doctor's Name**	**:Humaira**		
Payer Name	**: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:		
TPA	**: E CARE - Blue Network**	**Remarks**	:		
Validity	**: 11-12-2023** To **10-12-2024**				
Gender	**: Female**				
Date Of Birth	**: 11-May-1975**				
Patient's Tel No	**: 0545797666**				

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 dark colour urine heart burn epigastric pain 24th august 2024 oe EPIGastric pain chest is clear no ADDED SOUNDS RESTLESS history of hypertension and diabetes but do not have any deta **Duration:**

Vitals: Temp : 37.1 Bp :134 Pulse :84 Resp :18

Clinical Findings:

Diagnosis: K29.00 - Acute gastritis without bleeding,R10.13 - Epigastric pain,N39.0 - Urinary tract infection, site not specified, **Date of Onset** :27/57/2024

Requested Investigations: 9, Consultation GP,86677, ANTIBODY HELICOBACTER PYLORI,81001, URNLS DIP STICK/TABLET REAGENT AUTO MICROSCOPY,0005-136504-1021, SCOPINAL-(HYOSCINE : 20 MG/ML) SOLUTION FOR INJECTION,0005-242802-0781, PANTONIX 40MG I.V.-(PANTOPRAZOLE (AS SODIUM) : 40 MG) POWDER FOR INFUSION,96374, THER/PROPH/DIAG INJ IV PUSH,101, GENARAL WELNES CHECKUP (55 TEST) **Estimated Cost** :

Prescriptions: 0005-136501-0393 - (HYOSCINE : 10 MG) FILM COATED TABLETS,1267-141604-0082 - (ALUMINIUM HYDROXIDE : 200 MG) (MAGNESIUM HYDROXIDE : 200 MG) (SIMETHICONE : 25 MG) CHEWABLE TABLETS,0188-232402-0391 - (ESOMEPRAZOLE : 20 MG) FILM COATED TABLETS, **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.

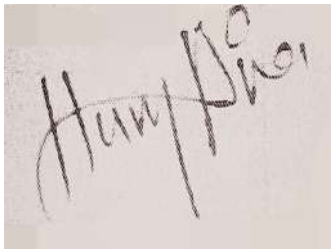
PATIENT'S DECLARATION :

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 :** 27-Aug-2024

Signature :  **Date** : 27-Aug-2024