

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name

: ROSHITHA NISHAN

Card No

: I017-029-116136842-02

Policy Holder

: ROSHITHA NISHAN

Payer Name

: WEERAKKODY MAHAWITHANALAGE

TPA

: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC

Validity

: E CARE - Green Network

Gender

: 01-01-1900 To 30-09-2024

Date Of Birth

: Male

Patient's Tel No

: 25-Jul-1986

: 0521553976

Service Date

: 02-Sep-2024

Health Provider

: CITICARE MEDICAL CENTER LLC

Doctor's Name

: AHSAN HUSSAIN

Co-Insurance

Network

: Green

Direct Access SP

: YES

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

Remarks

:

☐ Acute

☐ Pre-existing and chronic

☐ Maternity

Chief Complaints

: PC: FEVER SORETHROAT HEADACHE EPIGASTRIC PAIN

Vitals

: Temp : 36.4 Bp :116 Pulse :86 Resp :18

Clinical Findings:

Diagnosis

: J06.9 - Acute upper respiratory infection, unspecified,J00 - Acute nasopharyngitis [common cold],R10.13 Date of Onset :02/21/2024

Requested Investigations

: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,85651, SEDIMENTATION RATE RBC NON AUTOMATED,9, Consultation GP

Prescriptions

: 7512-014201-1161 - (ADHATODA VASICA : 112.5 MG/10ML) (TULSI (OCIMUM SANCTUM) : 90MG/10ML) (SOLANUM XANTHOCARPUM : 90MG/10ML) (TERMINALIA BELLIRICA EXTRACT : 52.5 MG/10ML) (HEDYCHIUM SPICATUM : 37.5 MG/10ML) (GLYCYRRHIZA GLABRA EXTRACT : 22.5 MG/10ML) (PIPER LONGUM : 22.5 MG/10ML) SYRUP,0005-938301-3381 - (CAFFEINE ANHYDROUS : 25 MG) (PARACETAMOL : 500 MG) (PHENYLEPHRINE HCL : 5 MG) CAPLET-TABLET,0139-116206-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS,0195-123701-0391 - CETIRIZINE HCL,

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

Signature

Stamp

Date

: 02-Sep-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

: 02-Sep-2024