

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : SANTOSH SINGH

Card No : I017-029-121182716-01

Policy Holder : SANTOSH SINGH

Payer Name : ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC

TPA : E CARE - Green Network

Validity : 09-08-2024 To 30-09-2024

Gender : Male

Date Of Birth : 15-May-1996

Patient's Tel No : +918755296376

Service Date :03-Sep-2024

Health Provider :CITICARE MEDICAL CENTER LLC

Doctor's Name :Humaira

Co-Insurance :

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

Remarks :

Network : Green

Direct Access SP - YES

☐ Acute

☐ Pre-existing and chronic

☐ Maternity

Chief Complaints : co fever bodyache dry cough running nose 31st august 2024 oe enlarge tonsills chest is congested no added sounds restless taking panADOL AT HOME

Duration:

Vitals:Temp : 37.1 Bp :139 Pulse :69 Resp :18

Clinical Findings:

Diagnosis: R50.9 - Fever, unspecified,J06.9 - Acute upper respiratory infection, unspecified,J30.9 - Allergic rhinitis, unspecified,R05 - Cough,K29.00 - Acute gastritis without bleeding,

Date of Onset :03/39/2024

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,0195-107704-0801, CEFTRIAXONE-TABUK IV,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,96372, THER/PROPH/DIAG INJ SC/IM,96365, THER/PROPH/DIAG IV INF INIT,9, Consultation GP

Estimated : Cost

Prescriptions: 4235-533801-1751 - (ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) GASTRO-RESISTANT TABLETS,0005-119805-1172 - (PREDNISOLONE : 5 MG) TABLETS,0097-393801-2471 - (AMMONIUM CHLORIDE : 131.5 MG/5 ML) (DIPHENHYDRAMINE HCL : 13.5 MG/5ML) SYRUP (ALCOHOL FREE),0005-107001-0051 - (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS,0139-116206-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS,0195-123701-0391 - (CETIRIZINE HCL : 10 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}

03-Sep-2024

Signature :

Date : 03-Sep-2024

https://irhamc.visionsoftwares.ae/mr_ecare_claim_print.aspx?appld=52298&patId=54050

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