Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **ANTHONY RICHARDSON JOHNSON**	**Service Date**	**:03-Sep-2024**	**Network**	**:** Green
Card No	: **I017-029-116122158-02**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**		**Direct Access S**
Policy Holder	: **ANTHONY RICHARDSON JOHNSON**	**Doctor's Name**	**:Humaira**		
Payer Name	: **ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:		
TPA	: **E CARE - Green Network**				
Validity	: **01-10-2023** To **30-09-2024**				
Gender	: **Male**	**Remarks**	:		
Date Of Birth	: **22-Oct-1985**				
Patient's Tel No	: **0553406129**				

CONSULTATION	LAB/ RADIOLOGY	PHYSIO	PHARMACY	IP	MATEF
10% max	NIL	NIL	NIL LIMIT	NIL	10%

☐ **Acute** ☐ **Pre-existing and chronic** ☐ **Maternity**

Chief Complaints : **Duration :**

Vitals:

Clinical Findings:

Diagnosis: R50.9 - Fever, unspecified,J06.9 - Acute upper respiratory infection, unspecified,R05 - Cough,K29.00 - Acute gastritis without bleeding,J03.90 - Acute tonsillitis, unspecified, **Date of Onset**

Requested Investigations: 9.01, Follow Up Consultation GP,96365, THER/PROPH/DIAG IV INF INIT,0195-107704-0801, CEFTRIAXONE-TABUK IV,86140, C REACTIVE PROTEIN **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 :

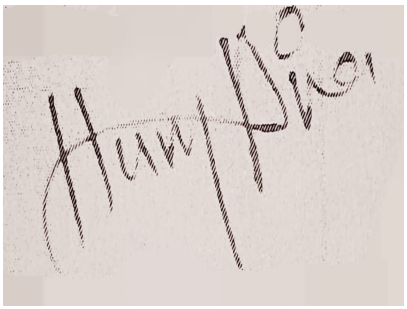
I hereby authorize any Healthcar or other organization to release a medical condition & history for p insurance benefits.

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}

Signature :  **Date :** 03-Sep-2024