

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name

: THARUKA NILSHANI

Card No

: I017-029-120835107-01

Policy Holder

: THARUKA NILSHANI

Holder

: DEVASURENDRA

Payer Name

: ABU DHABI NATIONAL

INSURANCE COMPANY-

ADNIC

TPA

: E CARE - Green Network

Validity

: 22-05-2024 To 30-09-2024

Gender

: Female

Date Of Birth

: 06-Aug-1990

Patient's Tel No

: 0569414971

Service Date

:06-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 : RUNNY NOSE COLD N FLU CONGESTION SORETHROAT

Duration :

Vitals

:Temp : 37 Bp :148 Pulse :98 Resp :18

Clinical Findings:

Diagnosis:

J06.9 - Acute upper respiratory infection, unspecified,J00 - Acute nasopharyngitis [common cold],R51.9 - Headache, unspecified,J30.9 - Allergic rhinitis, unspecified,

Date of Onset

:06/14/2024

Requested Investigations:

2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,0005-107704-0802, TRIAXONE I.V.-(CEFTRIAZONE : 1 G) POWDER FOR INJECTION,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,0005-174202-0781, RISEK 40MG,96365, THER/PROPH/DIAG IV INF INIT,96372, THER/PROPH/DIAG INJ SC/IM,9.01, Follow Up Consultation GP

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.

Dr's Name

: AHSAN HUSSAIN

Stamp :

Dr. Ahsan Hussain

General Practitioner

DHA No: 87543658-001

CITICARE MEDICAL CENTER LLC

DUBAI - U.A.E.

Signature :

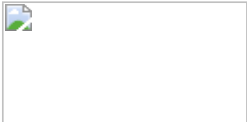


Date : 06-Sep-2024

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 : Sep-2024