Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: STANLEY MUIRURI WANJIRU**	**Service Date**	**:09-Sep-2024**	**Network**	**:** Green
Card No	**: I017-029-116954338-02**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**		**Direct Access SP - YES**
Policy Holder	**: STANLEY MUIRURI WANJIRU**	**Doctor's Name**	**:Humaira**		
Payer Name	**: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:		
TPA	**: E CARE - Green Network**	**Remarks**	**:**		
Validity	**: 01-10-2023** To **30-09-2024**				
Gender	**: Male**				
Date Of Birth	**: 25-Oct-1988**				
Patient's Tel No	**: 0569493860**				

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 fever running nose dry throat 4th sep. 2024 inthe morning blood is coming through the nose oe enlarge tonsills some laceration in the nose chest is clear no added sounds restless penadol cold at home **Duration:**

Vitals: Temp : 36.3 Bp :114 Pulse :74 Resp :18

Clinical Findings:

Diagnosis: R50.9 - Fever, unspecified,J06.9 - Acute upper respiratory infection, unspecified,J30.9 - Allergic rhinitis, unspecified,K29.00 - Acute gastritis without bleeding, **Date of Onset** :09/51/2024

Requested Investigations: 9, Consultation GP,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,85652, SEDIMENTATION RATE RBC AUTOMATED,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 **Estimated Cost :**

Prescriptions: 0207-533801-1451 - (ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) CAPSULES (HARD GELATIN),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.

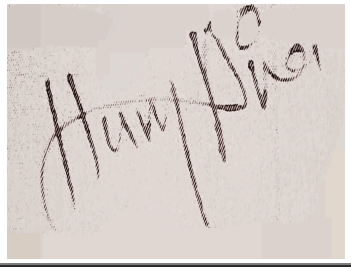
PATIENT'S DECLARATION :

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} : **Date :** 09-Sep-2024

Signature :  **Date** : 09-Sep-2024