Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **JULIE ROSE SUMANG FLORES**	**Service Date**	**:11-Sep-2024**
Card No	: **I017-029-120820677-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**
Policy Holder	: **JULIE ROSE SUMANG FLORES**	**Doctor's Name**	**:Humaira**
Payer Name	: **ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **21-05-2024** To **22-05-2025**		
Gender	: **Female**		
Date Of Birth	: **07-Oct-1979**		
Patient's Tel No	: **0502402893**		

Network : Green

Direct Access SP - YES

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 no menses from three months pain in the neck heavy weight lifting prulant cough 3rd sep. 2024 oe muscle spasms chest is congested restless **Duration:**

Vitals: Temp : 36.1 Bp :128 Pulse :82 Resp :18

Clinical Findings:

Diagnosis: M62.830 - Muscle spasm of back,J06.9 - Acute upper respiratory infection, unspecified,R05 - Cough,K29.00 - Acute gastritis without bleeding, **Date of Onset** :11/57/2024

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,0188-135906-2441, PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION,94640, AIRWAY INHALATION TREATMENT,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,96372, THER/PROPH/DIAG INJ SC/IM,84702, BETA,HCG,101, GENARAL WELNES CHECKUP (55 TEST),96365, THER/PROPH/DIAG IV INF INIT **Estimated Cost** :

Prescriptions: 0005-119805-1172 - (PREDNISOLONE : 5 MG) TABLETS,0207-533801-1451 - (ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) CAPSULES (HARD GELATIN),0005-107001-0051 - (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS,0252-179601-1161 - (AMMONIUM CHLORIDE : N/A) (MENTHOL : N/A) (DIPHENHYDRAMINE : 14 MG/5 ML) SYRUP,0139-116206-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS,2093-596002-0432 - (DICLOFENAC DIETHYLAMINE : 23.2 MG / G) GEL, **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.

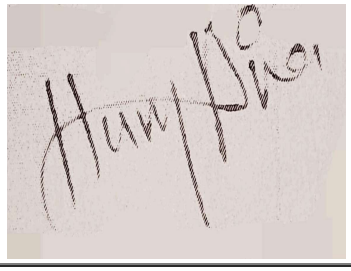
Dr's Name : Humaira

Stamp :

Patient 's signature{Parent if minor} :

Date : 11-Sep-2024

Signature :



Date : 11-Sep-2024