Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: KAOUTAR BENCHELHA	**Service Date**	:13-Sep-2024	**Network**	: Green
Card No	: I017-029-116461315-02	**Health Provider**	:CITICARE MEDICAL CENTER LLC	**Direct Access SP - YES**	
Policy Holder	: KAOUTAR BENCHELHA	**Doctor's Name**	:Humaira		
Payer Name	: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC	**Co-Insurance**	:		

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

TPA	: E CARE - Green Network	**Remarks**	:
Validity	: 01-10-2023 To 30-09-2024		
Gender	: Female		
Date Of Birth	: 13-Jul-1993		
Patient's Tel No	: 0563229007		

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

Chief Complaints : co fever on and off taking tablet penadol at home rt side ear paIN 9th sep. 2024 oe serous water is inside the rt. ear chest is clear no added sounds restless **Duration:**

Vitals: Temp : 36.8 Bp :110 Pulse :74 Resp :20

Clinical Findings:

Diagnosis: R50.9 - Fever, unspecified,H66.91 - Otitis media, unspecified, right ear,R52 - Pain, unspecified, **Date of Onset :**13/10/2024

Requested Investigations: 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,96365, THER/PROPH/DIAG IV INF INIT,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP **Estimated Cost :**

Prescriptions: 0005-107001-0051 - (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS,0195-116604-0391 - (METRONIDAZOLE : 500 MG) FILM COATED TABLETS,0333-143602-1171 - (CEFUROXIME : 500 MG) 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.

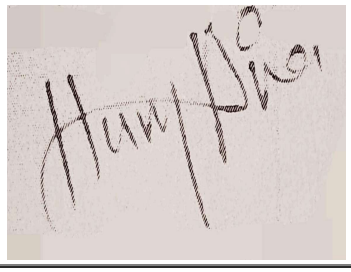
PATIENT'S DECLARATION :

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 :** 13-Sep-2024

Signature :  **Date** : 13-Sep-2024