Administrative **MEDICAL CLAIM FORM** **Claim Ref:**

Patient Name	: SATVIR DASS	**Service Date**	:15-Sep-2024	**Network**	: Green
Card No	: I017-029-114451195-02	**Health Provider**	:CITICARE MEDICAL CENTER LLC	**Direct Access SP - YES**	
Policy Holder	: SATVIR DASS	**Doctor's Name**	:AHSAN HUSSAIN		
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	: 01-Apr-1994				
Patient's Tel No	: 0509019956				

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 : PC: COLD N COUGH ALLERGIC RHINITIS **Duration :**

Vitals: Temp : 36.6 Bp :100 Pulse :72 Resp :18

Clinical Findings:

Diagnosis: J00 - Acute nasopharyngitis [common cold],J30.9 - Allergic rhinitis, unspecified, **Date of Onset** :16/17/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0005-128801-1971 - (XYLOMETAZOLINE HYDROCHLORIDE : 0.05%) LIQUID FOR SPRAY (NASAL),0252-185801-0391 - (DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS,0195-123701-0391 - CETIRIZINE HCL, **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 : AHSAN HUSSAIN **Stamp :**

Dr. Ahsan Hussain
General Practitioner
DHA No: 87543658-001
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

Patient 's signature{Parent if minor} : **Date :** 16-Sep-2024

Signature : **Date** : 16-Sep-2024