Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **ADITYA KUMAR SHIVCHANDRA THAKUR**	**Service Date**	**:22-Sep-2024**
Card No	: **I017-029-120929342-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**
Policy Holder	: **ADITYA KUMAR SHIVCHANDRA THAKUR**	**Doctor's Name**	**:AHSAN HUSSAIN**
Payer Name	: **ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:
TPA	: **E CARE - Green Network**	**Remarks**	:
Validity	: **14-06-2024** To **30-09-2024**		
Gender	: **Male**		
Date Of Birth	: **07-Feb-1999**		
Patient's Tel No	: **0509502547**		

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 : PC: FEVER FLU COLD BODY ACHES EPIGASTRIC PAIN LOW BACK PAIN **Duration :**

Vitals: Temp : 37 Bp :106 Pulse :74 Resp :18

Clinical Findings:

Diagnosis: R50.9 - Fever, unspecified,J30.9 - Allergic rhinitis, unspecified,K29.00 - Acute gastritis without bleeding,J06.9 - Acute upper respiratory infection, unspecified,M54.5 - Low back pain,J00 - Acute nasopharyngitis [common cold], **Date of Onset** :22/56/2024

Requested Investigations: 0005-149902-1021, CLOFEN ,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,0005-107704-0802, TRIAXONE I.V.-(CEFTRIAXONE : 1 G) POWDER FOR INJECTION,0005-174202-0781, RISEK 40MG,2190-106618-1001, PARAFUSIV,96365, THER/PROPH/DIAG IV INF INIT,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP **Estimated Cost** :

Prescriptions: 0207-533801-1451 - (ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) CAPSULES (HARD GELATIN),0027-265802-1161 - (BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V) SYRUP,0252-185801-0391 - (DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS,0139-116206-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) 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** : 22-Sep-2024

Signature : **Date** : 22-Sep-2024