Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: TENNEH CONTEH**
Card No	**: I005-029-118940677-01**
Policy Holder	**: TENNEH CONTEH**
Payer Name	**: DUBAI INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 13-05-2024** To **12-05-2025**
Gender	**: Female**
Date Of Birth	**: 03-Dec-1992**
Patient's Tel No	**: 0581794461**

Service Date **:24-Sep-2024** **Network** : Green

Health Provider **:CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**

Doctor's Name **:AHSAN HUSSAIN**

Co-Insurance :

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

Remarks :

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

Chief Complaints : PC:COUGH FEVER FLU BODY PAIN HEADACHE LOW BACK PAIN ITCHING AROUND VAGINA EPIGASTRIC PAIN **Duration:**

Vitals: Temp : 36.9 Bp :116 Pulse :72 Resp :18

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,J00 - Acute nasopharyngitis [common cold],R05 - Cough,M54.5 - Low back pain,R10.13 - Epigastric pain,N76.0 - Acute vaginitis, **Date of Onset** :24/01/2024

Requested Investigations: 0005-107704-0802, TRIAXONE I.V.-(CEFTRIAXONE : 1 G) POWDER FOR INJECTION,2190-106618-1001, PARAFUSIV,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,0005-174202-0781, RISEK 40MG,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,0188-135906-2441, PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION,94640, AIRWAY INHALATION TREATMENT,9, Consultation GP,96372, THER/PROPH/DIAG INJ SC/IM,96365, THER/PROPH/DIAG IV INF INIT **Estimated Cost** :

Prescriptions: 0186-143701-0061 - (CELECOXIB : 200 MG) CAPSULES,0252-185801-0391 - (DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS,0027-265802-1161 - (BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V) SYRUP,0139-116206-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS,0195-123701-0391 - CETIRIZINE HCL, **Estimated Cost** :

MEDICAL PRACTITIONER DECLARATION :

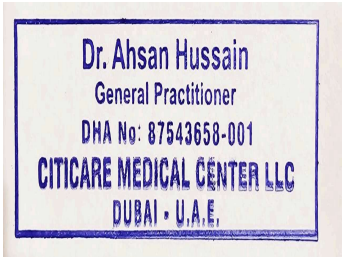
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

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

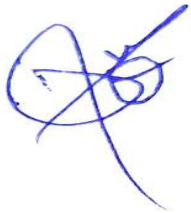
Stamp :



Patient 's signature{Parent if minor} :

Date : 24-Sep-2024

Signature :



Date : 24-Sep-2024