Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **KHADEEJATHU SHANA KHADEEJATHU**	**Service Date**	**:24-Sep-2024**
Card No	: **I017-029-120953197-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**
Policy Holder	: **KHADEEJATHU SHANA KHADEEJATHU**	**Doctor's Name**	**:AHSAN HUSSAIN**
Payer Name	: **ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **24-06-2024** To **23-06-2025**		
Gender	: **Female**		
Date Of Birth	: **20-Sep-1996**		
Patient's Tel No	: **0558613258**		

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 HEADACHE LOW BACK PAIN RUNNY NOSE BODY PAIN **Duration:**

Vitals: Temp : 38.3 Bp :132 Pulse :131 Resp :18

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,J00 - Acute nasopharyngitis [common cold],M54.5 - Low back pain,R51.9 - Headache, unspecified,J30.9 - Allergic rhinitis, unspecified, **Date of Onset** :24/41/2024

Requested Investigations: 0005-107704-0802, TRIAXONE I.V.-(CEFTRIAXONE : 1 G) POWDER FOR INJECTION,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,2190-106618-1001, PARAFUSIV,0188-135906-2441, PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION,94640, AIRWAY INHALATION TREATMENT,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,96372, THER/PROPH/DIAG INJ SC/IM,96365, THER/PROPH/DIAG IV INF INIT,0005-149902-1021, CLOFEN ,9, Consultation GP **Estimated Cost** :

Prescriptions: 0355-128801-2021 - (XYLOMETAZOLINE HYDROCHLORIDE : 0.05%) NASAL DROPS,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 :

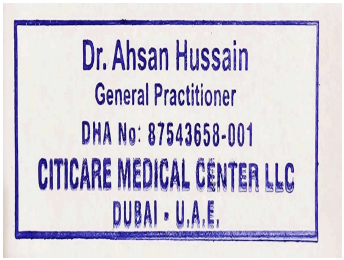
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

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

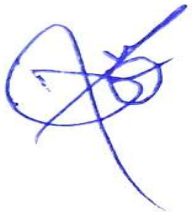
Stamp :



Patient 's signature{Parent if minor} :

Date : 24-Sep-2024

Signature :



Date : 24-Sep-2024