Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: JOHN BARRY OMONDI	**Service Date**	:24-Sep-2024	**Network**	: Green
Card No	: I017-029-119050814-01	**Health Provider**	:CITICARE MEDICAL CENTER LLC		**Direct Access SP - YES**
Policy Holder	: JOHN BARRY OMONDI	**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	: 04-Nov-1999				
Patient's Tel No	: 0555219621				

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: adenitis lymph node swlling and also in under arm **Duration :**

Vitals: Temp : 36.9 Bp :136 Pulse :64 Resp :18

Clinical Findings:

Diagnosis: L04.9 - Acute lymphadenitis, unspecified,L75.9 - Apocrine sweat disorder, unspecified, **Date of Onset :**24/57/2024

Requested Investigations: 0005-107704-0802, TRIAXONE I.V.-(CEFTRIAXONE : 1 G) POWDER FOR INJECTION,96365, THER/PROPH/DIAG IV INF INIT,0005-149902-1021, CLOFEN ,96372, THER/PROPH/DIAG INJ SC/IM,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,9, Consultation GP **Estimated Cost :**

Prescriptions: 0277-165001-0061 - (ETAMSYLATE : 500 MG) CAPSULES,2696-159502-0061 - (SERRATIOPEPTIDASE : 10 MG) CAPSULES,2626-293402-0391 - (LINEZOLID : 600 MG) FILM COATED 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 : 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 :** 24-Sep-2024

Signature : **Date** : 24-Sep-2024