Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **UJWALA PANDURANG SHELKE PANDURANG DASHRATH SHELKE**	**Service Date**	**:24-Sep-2024**	**Network**	**:** Green
Card No	**: I017-029-117009982-02**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**		**Direct Access S**
Policy Holder	: **UJWALA PANDURANG SHELKE PANDURANG DASHRATH SHELKE**	**Doctor's Name**	**:AHSAN HUSSAIN**		
Payer Name	: **ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:		
TPA	**: E CARE - Green Network**				
Validity	**: 01-10-2023** To **30-09-2024**				
Gender	**: Female**	**Remarks**	**:**		
Date Of Birth	**: 18-Feb-1997**				
Patient's Tel No	**: 0503449424**				

CONSULTATION	LAB/ RADIOLOGY	PHYSIO	PHARMACY	IP	MATEF
10% max	NIL	NIL	NIL LIMIT	NIL	10%

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

Chief Complaints : PC: FEVER COLD FLU SORE THROAT LETHARGY BODY PAIN SORE THROAT **Duration :**

Vitals: Temp : 36.9 Bp :106 Pulse :102 Resp :18

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,J00 - Acute nasopharyngitis [common cold],R50.9 - Fever, unspecified,M54.5 - Low back pain,M62.830 - Muscle spasm of back,M83.3 - Adult osteomalacia due to malnutrition,R07.1 - Chest pain on breathing,K21.9 - Gastro-esophageal reflux disease without esophagitis,R53.1 - Weakness, **Date o Onset**

Requested Investigations: 82652, 1 25 DIHYDROXY INCLUDES FRACTIONS IF PERFORMED,0188-135906-2441, PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION,94640, AIRWAY INHALATION TREATMENT,9, Consultation GP **Estimated Cost :**

Prescriptions: 1217-373201-2401 - TOLPERISONE HCL,0005-938301-3381 - (CAFFEINE ANHYDROUS : 25 MG) (PARACETAMOL : 500 MG) (PHENYLEPHRINE HCL : 5 MG) CAPLET-TABLET,0139-116206-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS,0195-123701-0391 - CETIRIZINE HCL, **Estimated Cost :**

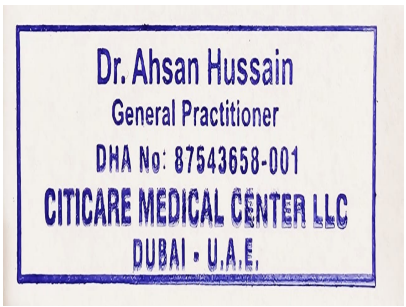
MEDICAL PRACTITIONER DECLARATION :

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.

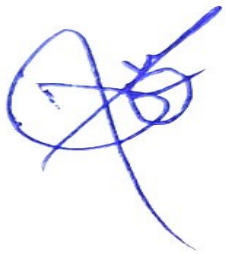
PATIENT'S DECLARATION :

I hereby authorize any Healthcar or other organization to release a medical condition & history for p insurance benefits.

Dr's Name : AHSAN HUSSAIN **Stamp :**



Patient 's signature{Parent if minor} :

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