

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : isthiaque mustaque ahmed

Card No : I017-029-120574863-01

Policy Holder : isthiaque mustaque ahmed

Payer Name : ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC

TPA : E CARE - Green Network

Validity : 01-10-2023 To 30-09-2024

Gender : Male

Date Of Birth : 06-Dec-1988

Patient's Tel No : 0527527324

Service Date :24-Sep-2024

Health Provider :CITICARE MEDICAL CENTER LLC

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 :

Network : Green

Direct Access SP - YES

☐ Acute

☐ Pre-existing and chronic

☐ Maternity

Chief Complaints : PC: FEVER FLU RUNNY NOSE SORE THROAT BODY PAIN Duration :

Vitals:Temp : 37.1 Bp :113 Pulse :81 Resp :18

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,J00 - Acute nasopharyngitis [common cold],M54.5 - Low back pain,J30.9 - Allergic rhinitis, unspecified,M62.830 - Muscle spasm of back, Date of Onset :24/04/2024

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

Prescriptions: 0355-128801-2021 - (XYLOMETAZOLINE HYDROCHLORIDE : 0.05%) NASAL DROPS,0186-143701-0062 - (CELECOXIB : 200 MG) CAPSULES,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

Dr's Name : AHSAN HUSSAIN

Stamp :

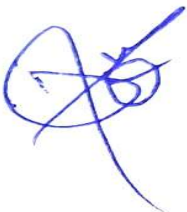
Dr. Ahsan Hussain

General Practitioner

DHA No: 87543658-001

CITICARE MEDICAL CENTER LLC

DUBAI - U.A.E,

Signature :

Date : 24-Sep-2024

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.

Patient 's signature{Parent : if minor}



Date : Sep-2024