

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name

: KEIT NIKKI CHETTE
MAGLABE VILLARIN

Card No

: I017-029-118932957-01

Policy Holder

: KEIT NIKKI CHETTE
MAGLABE VILLARIN

Payer Name

: ABU DHABI NATIONAL
INSURANCE COMPANY-
ADNIC

TPA

: E CARE - Green Network

Validity

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

Gender

: Female

Date Of Birth

: 01-Oct-2001

Patient's Tel No

: 0525114128

Service Date

:24-Sep-2024

Health Provider

:CITICARE MEDICAL CENTER LLC

Doctor's Name

:AHSAN HUSSAIN

Co-Insurance

Network

: Green

Direct Access SP

: YES

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: FEVER FLU COLD BODY PAIN

Duration :

Vitals:Temp : 38.3 Bp :92 Pulse :112 Resp :18

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,J00 - Acute nasopharyngitis [common cold],M62.830 - Muscle spasm of back,M54.5 - Low back pain,

Date of Onset :24/59/2024

Requested Investigations: 0005-107704-0802, TRIAXONE I.V.-(CEFTRIAZONE : 1 G) POWDER FOR INJECTION,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,96365, THER/PROPH/DIAG IV INF INIT,96372, THER/PROPH/DIAG INJ SC/IM,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

Estimated :
Cost

Prescriptions: 0788-106705-1171 - (CHLORPHENIRAMINE MALEATE : 2 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) TABLETS,0139-116206-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS,0195-123701-0391 - CETIRIZINE HCL,

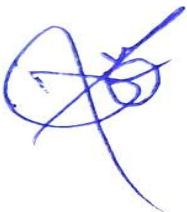
Estimated :
Cost

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}



24-Sep-2024

https://irhamc.visionsoftwares.ae/mr_ecare_claim_print.aspx?appld=53096&patId=40344

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