Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: AMINA MOHAMED ABDELAZIM ABDELMAQSOUD**
Card No	**: I017-029-121075946-03**
Policy Holder	**: AMINA MOHAMED ABDELAZIM ABDELMAQSOUD**
Payer Name	**: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**
TPA	**: E CARE - Green Network**
Validity	**: 06-01-2025** To **05-01-2026**
Gender	**: Female**
Date Of Birth	**: 05-Aug-1998**
Patient's Tel No	**: 547977506**

Service Date	**:17-Jan-2025**	**Network**	**:** Green
Health Provider	**:CITICARE MEDICAL CENTER LLC**		**Direct Access SP - YES**
Doctor's Name	**:SANDIA**		

Co-Insurance :

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 : neck pain , fever , dry cough , diahrreoa , palpitations sneezing , nasal blockage o?e hyperemia of pharynx tacycardia **Duration:**

Vitals: Temp : 37.8 Bp :126 Pulse :99 Resp :18

Clinical Findings:

Diagnosis: J02.9 - Acute pharyngitis, unspecified,R05 - Cough,R00.2 - Palpitations,R50.9 - Fever, unspecified, **Date of Onset :**17/16/2025

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,9, Consultation GP **Estimated Cost :**

Prescriptions: 1217-373201-2401 - (TOLPERISONE : 150 MG) SUGAR COATED TABLETS,2093-596002-0432 - (DICLOFENAC DIETHYLAMINE : 23.2 MG / G) GEL,0005-107001-0051 - (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS,0397-116207-0391 - (AMOXICILLIN : 500 MG (CLAVULANIC ACID : 125 MG FILM COATED TABLETS,0195-123701-0391 - (CETIRIZINE HCL : 10 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.

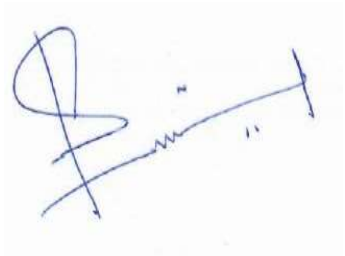
Dr's Name : SANDIA

Stamp :

Patient 's signature{Parent if minor} :

Date : 17-Jan-2025

Signature :



Date : 17-Jan-2025