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 **:15-Mar-2025** **Network** **:** Green

Health Provider **:CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**

Doctor's Name **:DR Amaizah**

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 ; SORE THROAT , SNEEZING , BODYPAIN , FEVER IS LOW GRADE STARTED **Duration:**
13/03/25 O/E : LOOK LETHARGIC , DEHYDRATED TONSILLER HYPERTROPHY HYPEREMIC PHARYNX CHEST CONGESTED

Vitals: Temp : 37 Bp :122 Pulse :86 Resp :18

Clinical Findings:

Diagnosis: J03.90 - Acute tonsillitis, unspecified,R50.9 - Fever, unspecified,J30.9 - Allergic rhinitis, unspecified, **Date of Onset :**15/43/2025

Requested Investigations: 2190-106618-1001, PARAFUSIV,0195-107704-0802, CEFTRIAXONE-TABUK IM,0005-111805-1021, CHLOROHISTOL 10MG-(CHLORPHENIRAMINE MALEATE : 10 MG/ML) SOLUTION FOR INJECTION,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,94640, AIRWAY INHALATION TREATMENT,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,0102-152902-1001, LACTATED RINGERS INJECTION USP,96360, HYDRATION IV INFUSION INIT,96372, THER/PROPH/DIAG INJ SC/IM,96365, THER/PROPH/DIAG IV INF INIT,9, Consultation GP,0188-135906-2441, PULMICORT **Estimated Cost :**

Prescriptions: 0006-106601-0392 - (PARACETAMOL : 500 MG) FILM COATED TABLETS,6705-602505-3801 - (HYDROXYPROPYLMETHYLCELLULOSE : 150 MG/ 30ML) SPRAY SOLUTION,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,0005-119803-1171 - (PREDNISOLONE : 20 MG) TABLETS,0397-116207-0391 - (AMOXICILLIN : 500 MG (CLAVULANIC ACID : 125 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 :

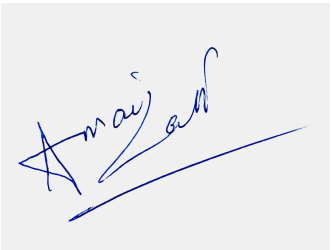
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : DR Amaizah **Stamp :**

Dr. Amaizah Ishtiaq
General Practitioner
DHA: 98486553-001
CITICARE MEDICAL CENTER
DUBAI - U.A.E

Patient 's signature{Parent : if minor}

Date : 15-Mar-2025

Signature : 

Date : 15-Mar-2025