Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **RHEA MARIE CABINGAS TAGARAO**	**Service Date**	**:16-Jun-2025** **Network** : Green
Card No	: **I017-029-114807837-02**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **RHEA MARIE CABINGAS TAGARAO**	**Doctor's Name**	**:Dr.Farhan Iyas**
Payer Name	: **ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **13-11-2024** To **12-11-2025**		
Gender	: **Female**		
Date Of Birth	: **15-Nov-1985**		
Patient's Tel No	: **0553341884**		

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

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

Chief Complaints : patient came with cough and sore throat started 4 days ago 12/06/26 associated with headache, body pain, weakness and nasal congestion and pain while swallowing on examination: throat is hyperemic and chest congestion previous history: only seasonal diseases allergy: no allergy with medicine or anything. **Duration:**

Vitals: Temp : 36.8 Bp :140 Pulse :76 Resp :18

Clinical Findings:

Diagnosis: J02.9 - Acute pharyngitis, unspecified,R05 - Cough,R50.9 - Fever, unspecified,R52 - Pain, unspecified,R09.81 - Nasal congestion,R53.1 - Weakness,R06.2 - Wheezing, **Date of Onset** :16/32/2025

Requested Investigations: 0188-135906-2441, PULMICORT,85004, BLOOD COUNT AUTOMATED DIFFERENTIAL WBC COUNT,86140, C REACTIVE PROTEIN,94640, AIRWAY INHALATION TREATMENT,9, Consultation GP **Estimated Cost** :

Prescriptions: 0207-169703-1161 - (AMMONIUM CHLORIDE : N/A) (DIPHENHYDRAMINE : N/A) SYRUP,0006-106601-0394 - (PARACETAMOL : 500 MG) FILM COATED TABLETS,0252-389902-1171 - (LORATADINE : 5 MG) (PSEUDOEPHEDRINE SULPHATE : 120 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.

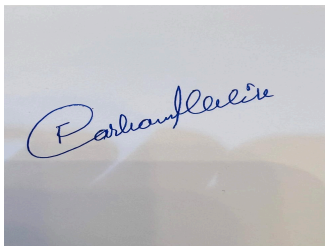
Dr's Name : Dr.Farhan Iyas

Stamp :

Dr .Frahan Ilyas Malik
Physician-General Practitioner
DHA-06441782-001
CITICARE MEDICAL CENTER
DUBAI U.A.E

Patient 's signature{Parent if minor} :

Date : 16-Jun-2025

Signature : 

Date : 16-Jun-2025