## **Administrative**

## **MEDICAL CLAIM FORM**

## **Claim Ref:**

: RHEA MARIE CABINGAS TAGARAO **Patient** 

Service Date

:18-Jun-2025

: Green

Name **Card No** 

Health Provider

:CITICARE MEDICAL CENTER LLC

Policy

: 1017-029-114807837-02

Doctor's

**Direct Access SP - YES** 

Holder

: RHEA MARIE CABINGAS : TAGARAO

Name

:Dr.Farhan Iyas

Payer Name

**ABU DHABI NATIONAL** : INSURANCE COMPANY- Co-

Insurance

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

Network

ADNIC TPA

: E CARE - Blue Network

Parlamflulite

Signature:

Validity : 13-11-2024 To 12-11-2025

: Female

Gender Date Of

Birth

: 15-Nov-1985

Patient's

· 05522/199/

Remarks

Acute	Pre-existing and chronic		☐ Maternity		
Chief Complaints : follow up investigation: there is elevat	patient yesterday came with ed CRP in report.	acute pharyngitis and done	Duration:		
Vitals:Temp : 36.6 Bp :116 P	ulse :72 Resp :18				
Clinical Findings:					
Diagnosis: R79.82 - Elevated	C-reactive protein (CRP),J02.	9 - Acute pharyngitis, unspecified,	Date of C	Onset :18/45/2025	
LACTATED RINGERS INJECTIO	ON USP,0125-122107-1022, DI ML) SOLUTION FOR INJECTION	DNE-TABUK 1 GM IV,0439-152905-1 EXAMETHASONE SODIUM PHOSPH N,96365, THER/PROPH/DIAG IV INF	ATE- Cost		
Prescriptions:	Estimated Cost	:			
MEDICAL PRACTITIONER D	ECLARATION :		PATIENT'S DECLARATION	N:	
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.			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 : Dr.Farhan Iyas	Stamp :	Dr .Frahan Ilyas Malik Physician-General Practitioner DHA-06441782-001 CITICARE MEDICAL CENTER	Patient 's signature{Parent : if minor}	18- <b>Date</b> : Jun- 2025	

Date: 18-Jun-2025