Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: RACHEL BENDADA**	**Service Date**	**:05-Aug-2025**
Card No	**: I017-029-121844166-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**
Policy Holder	**: RACHEL BENDADA**	**Doctor's Name**	**:AISHA**
Payer Name	**: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:
TPA	**: E CARE - Blue Network**	**Remarks**	:
Validity	**: 07-02-2025** To **06-02-2026**		
Gender	**: Female**		
Date Of Birth	**: 21-May-1997**		
Patient's Tel No	**: 0543268307**		

Network : Green

Direct Access SP - YES

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 : pc : high grade fever ,throat pain ,runny nose ,body pain hopc : pt came with **Duration:** the complain of throat pain along with high grade fever started this morning she also has sever body pain o/e throat is hyperemic chest is clear tonsils are hypertrophied

Vitals: Temp : 39.1 Bp :130 Pulse :78 Resp :18

Clinical Findings:

Diagnosis: J03.90 - Acute tonsillitis, unspecified,R50.9 - Fever, unspecified,R07.0 - Pain in throat,J30.89 - Other allergic rhinitis,E86.0 - Dehydration,R05 - Cough,

Date of Onset :05/02/2025

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,2190-106618-1001, PARAFUSIV,96365, THER/PROPH/DIAG IV INF INIT,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,0005-149902-1021, CLOFEN ,96372, THER/PROPH/DIAG INJ SC/IM,0195-107704-0801, CEFTRIAXONE-TABUK IV,96374, THER/PROPH/DIAG INJ IV PUSH,0384-111908-1001, SODIUM CHLORIDE B.P.,96360, HYDRATION IV INFUSION INIT,9, Consultation GP

Estimated Cost :

Prescriptions: 0005-119803-1171 - (PREDNISOLONE : 20 MG) TABLETS,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,0250-125820-3931 - (POVIDONE IODINE : 1%) MOUTHWASH-SOLUTION,0005-107001-0052 - (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS,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 : AISHA

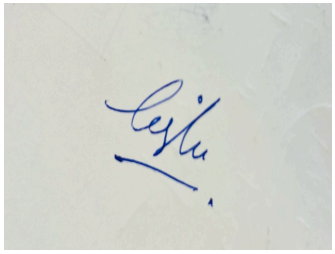
Stamp :

Dr. Aisha Umer
Physician- General Practitioner
DHA- 40131439-002
CITICARE MEDICAL CENTER
DUBAI - U.A.E

Patient 's signature{Parent : if minor}

Date : 05-Aug-2025

Signature :



Date : 05-Aug-2025