Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: PRAHLAD SINGH**	**Service Date**	**:14-Aug-2024**
Card No	**: I017-029-119171364-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**
Policy Holder	**: PRAHLAD SINGH**	**Doctor's Name**	**:Humaira**
Payer Name	**: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	**:**
TPA	**: E CARE - Green Network**	**Remarks**	**:**
Validity	**: 01-10-2023** To **30-09-2024**		
Gender	**: Male**		
Date Of Birth	**: 06-Apr-1983**		
Patient's Tel No	**: 0506858637**		

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 : co fever on and off diarrhea crampy abdominal pain 7 times in a day 10th august 2024 oe abdominal pain chest is clear no added sounds dehydrated restless **Duration:**

Vitals: Temp : 36.4 Bp :120 Pulse :64 Resp :18

Clinical Findings:

Diagnosis: R50.9 - Fever, unspecified,R19.7 - Diarrhea, unspecified,R10.9 - Unspecified abdominal pain, **Date of Onset :**14/10/2024

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,85652, SEDIMENTATION RATE RBC AUTOMATED,0195-107704-0801, CEFTRIAXONE-TABUK IV,96365, THER/PROPH/DIAG IV INF INIT,0102-111908-1001, SODIUM CHLORIDE B.P.,96360, HYDRATION IV INFUSION INIT,0005-136504-1021, SCOPINAL-(HYOSCINE : 20 MG/ML) SOLUTION FOR INJECTION,96374, THER/PROPH/DIAG INJ IV PUSH,87046, CUL BACT STOOL AEROBIC ADDL PATHOGENS&ID EA,9, Consultation GP **Estimated Cost :**

Prescriptions: 0005-107001-0051 - (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS,1795-502202-1451 - (SPORE OF BACILLUS CLAUSI : 2 BILLION) CAPSULES (HARD GELATIN),0097-230603-0832 - (ORAL REHYDRATION SALTS (O.R.S.) : N/A) POWDER FOR SOLUTION,0195-116604-0391 - (METRONIDAZOLE : 500 MG) FILM COATED TABLETS,3114-482003-0391 - (CIPROFLOXACIN (AS HYDROCHLORIDE) : 500 MG) FILM COATED TABLETS, **Estimated Cost :**

MEDICAL PRACTITIONER DECLARATION :

PATIENT'S 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.

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.

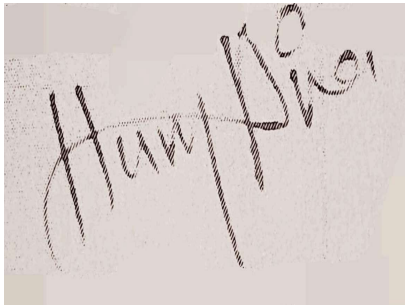
Dr's Name : Humaira

Stamp :

Dr. Humaira Mumtaz
General Practitioner
DHA No: 54155530-002
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

Patient 's signature{Parent : if minor}

Date : 14-Aug-2024

Signature : 

Date : 14-Aug-2024