Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **NADA MAHMOUD . MOHAMED ABDELFATTAH**	**Service Date**	**:28-Aug-2024**	**Network**	: Green
Card No	: **I040-029-121069489-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**	**Direct Access SP - YES**	
Policy Holder	: **NADA MAHMOUD . MOHAMED ABDELFATTAH**	**Doctor's Name**	**:AHSAN HUSSAIN**		
Payer Name	: **UNION INSURANCE COMPANY**	**Co-Insurance**	:		
TPA	: **E CARE - Blue Network**	**Remarks**	:		
Validity	: **16-07-2024** To **01-01-2025**				
Gender	: **Female**				
Date Of Birth	: **01-Jan-1995**				
Patient's Tel No	: **0502718045**				

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: FEVER SORETHROAT HEADACHE COUGH **Duration :**

Vitals: Temp : 38.2 Bp :104 Pulse :98 Resp :18

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,J00 - Acute nasopharyngitis [common cold],R10.13 - Epigastric pain, **Date of Onset** :28/31/2024

Requested Investigations: 0005-174202-0781, RISEK 40MG,0005-107704-0802, TRIAXONE I.V.-(CEFTRIAXONE : 1 G) POWDER FOR INJECTION,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,96365, THER/PROPH/DIAG IV INF INIT,96372, THER/PROPH/DIAG INJ SC/IM,85004, BLOOD COUNT AUTOMATED DIFFERENTIAL WBC COUNT,86140, C REACTIVE PROTEIN,9, Consultation GP **Estimated Cost :**

Prescriptions: 0005-150407-1172 - (METOCLOPRAMIDE : 10 MG) TABLETS,0005-128801-1971 - (XYLOMETAZOLINE HYDROCHLORIDE : 0.05%) LIQUID FOR SPRAY (NASAL),0252-185801-0391 - (DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS,0139-116206-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS,0195-123701-0391 - CETIRIZINE HCL, **Estimated Cost :**

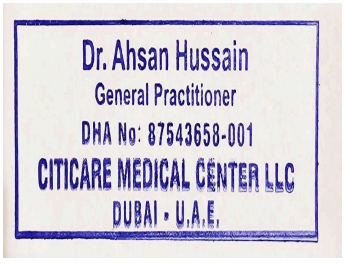
MEDICAL PRACTITIONER DECLARATION :

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.

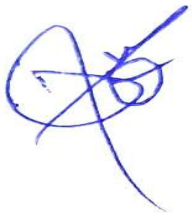
Dr's Name : AHSAN HUSSAIN **Stamp :**



Patient 's signature{Parent if minor} :

Date : 28-Aug-2024

Signature :



Date : 28-Aug-2024