

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : NINGMA SHERPA
Card No : I017-029-120688209-01
Policy Holder : NINGMA SHERPA
Payer Name : ABU DHABI NATIONAL
INSURANCE COMPANY-ADNIC
TPA : E CARE - Green Network
Validity : 16-04-2024 To 30-09-2024
Gender : Male
Date Of Birth : 11-Jul-2000
Patient's Tel No : 056960870

Service Date : 12-Sep-2024 Network : Green
Health Provider : CITICARE MEDICAL CENTER LLC Direct Access SP - YES
Doctor's Name : Humaira

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

Remarks :

☐ Acute ☐ Pre-existing and chronic ☐ Maternity

Chief Complaints : co prulant cough fever on and off 3rd sep . 2024 oe chest is wheezing
restless smoker taking penadol at home

Duration:

Vitals:Temp : 36.8 Bp :135 Pulse :71 Resp :18

Clinical Findings:

Diagnosis: R50.9 - Fever, unspecified,J06.9 - Acute upper respiratory infection, unspecified,R05 - Cough,K29.00 -
Acute gastritis without bleeding,J02.9 - Acute pharyngitis, unspecified, Date of Onset :12/59/2024

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,0188-135906-2441, PULMICORT-
(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION,94640, AIRWAY INHALATION
TREATMENT,INJ051, INJ-HYDROCORTISONE 100 MG/2ML,9, Consultation GP

Estimated :
Cost

Prescriptions: 0097-127405-0391 - (AZITHROMYCIN : 500 MG) FILM COATED TABLETS,0219-533801-
0391 - (ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) FILM COATED TABLETS,0252-179601-1161 -
(AMMONIUM CHLORIDE : N/A) (MENTHOL : N/A) (DIPHENHYDRAMINE : 14 MG/5 ML) SYRUP,0005-
107001-0051 - (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS,0005-119805-1172 -
(PREDNISOLONE : 5 MG) TABLETS,2118-290301-0391 - LEVOCETIRIZINE DIHYDROCHLORIDE,

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 : Humaira

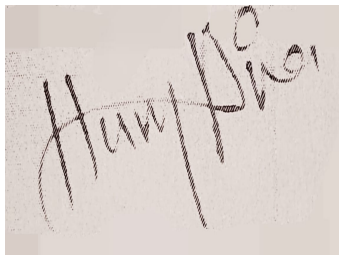
Stamp :

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

Patient 's
signature{Parent :
if minor}

12-
Date : Sep-
2024

Signature :



Date : 12-Sep-2024