Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: NINGMA SHERPA**	**Service Date**	**:12-Sep-2024**
Card No	**: I017-029-120688209-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**
Policy Holder	**: NINGMA SHERPA**	**Doctor's Name**	**:Humaira**
Payer Name	**: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	**:**
TPA	**: E CARE - Green Network**	**Remarks**	**:**
Validity	**: 16-04-2024** To **30-09-2024**		
Gender	**: Male**		
Date Of Birth	**: 11-Jul-2000**		
Patient's Tel No	**: 056960870**		

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

Network : Green

Direct Access SP - YES

☐ **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} : **Date :** 12-Sep-2024

Signature : **Date** : 12-Sep-2024