Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **ADITYA KUMAR SHIVCHANDRA THAKUR**	**Service Date**	**:13-Sep-2024** **Network** : Green
Card No	: **I017-029-120929342-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **ADITYA KUMAR SHIVCHANDRA THAKUR**	**Doctor's Name**	**:Humaira**
Payer Name	: **ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:
TPA	: **E CARE - Green Network**	**Remarks**	:
Validity	: **14-06-2024** To **30-09-2024**		
Gender	: **Male**		
Date Of Birth	: **07-Feb-1999**		
Patient's Tel No	: **0509502547**		

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 running nose bodyache dark colour of urine 9th sep. 2024 oe enlarge tonsills chest is clear no added sounds restless **Duration:**

Vitals: Temp : 38.8 Bp :100 Pulse :98 Resp :18

Clinical Findings:

Diagnosis: R50.9 - Fever, unspecified,J30.9 - Allergic rhinitis, unspecified,J06.9 - Acute upper respiratory infection, unspecified,K29.00 - Acute gastritis without bleeding,R52 - Pain, unspecified, **Date of Onset** :13/45/2024

Requested Investigations: 9, Consultation GP,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,85652, SEDIMENTATION RATE RBC AUTOMATED,2190-106618-1001, PARAFUSIV,0195-107704-0801, CEFTRIAXONE-TABUK IV,0005-149902-1021, CLOFEN - (DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,96365, THER/PROPH/DIAG IV INF INIT,96372, THER/PROPH/DIAG INJ SC/IM,0102-100104-1001, SODIUM CHLORIDE & DEXTROSE B.P.,96360, HYDRATION IV INFUSION INIT,96360, HYDRATION IV INFUSION INIT **Estimated Cost** :

Prescriptions: 0207-533801-1451 - (ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) CAPSULES (HARD GELATIN),0005-107001-0051 - (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS,0139-116206-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS,0195-123701-0391 - (CETIRIZINE HCL : 10 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.

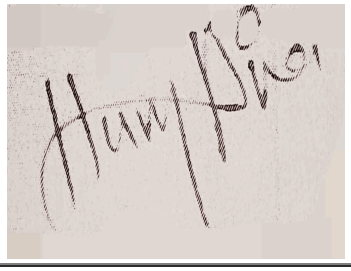
PATIENT'S DECLARATION :

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 : 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** : 13-Sep-2024

Signature :  **Date** : 13-Sep-2024