

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : HYDERALI ALLABAX
DUKANDAR
Card No : I017-029-116122248-02
Policy Holder : HYDERALI ALLABAX
DUKANDAR
Payer Name : ABU DHABI NATIONAL
INSURANCE COMPANY-ADNIC
TPA : E CARE - Green Network
Validity : 01-10-2023 To 30-09-2024
Gender : Male
Date Of Birth : 24-Dec-1989
Patient's Tel No : 0552906380

Service Date : 27-Sep-2024
Health Provider : CITICARE MEDICAL CENTER LLC
Doctor's Name : AHSAN HUSSAIN
Co-Insurance :

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

Network : Green
Direct Access SP - YES

Remarks :

☐ Acute ☐ Pre-existing and chronic ☐ Maternity

Chief Complaints : PC: FEVER FLU SORETHROAT EPIGASTRIC PAIN COUGH Duration :

Vitals:Temp : 36.8 Bp :95 Pulse :83 Resp :18

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,J00 - Acute nasopharyngitis [common cold],K21.9 - Date of :27/42/2024
Gastro-esophageal reflux disease without esophagitis,R05 - Cough,M54.5 - Low back pain, Onset

Requested Investigations: 0005-107704-0802, TRIAXONE I.V.-(CEFTRIAXONE : 1 G) POWDER FOR INJECTION,0005-174202-0781, RISEK 40MG,2190-106618-1001, PARAFUSIV,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,96365, THER/PROPH/DIAG IV INF INIT,96372, THER/PROPH/DIAG INJ SC/IM,0188-135906-2441, PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION,94640, AIRWAY INHALATION TREATMENT,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,9, Consultation GP

Estimated :
Cost

Prescriptions: 0027-265802-1161 - (BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V) SYRUP,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 :

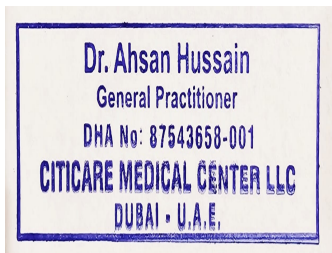
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

PATIENT'S DECLARATION :

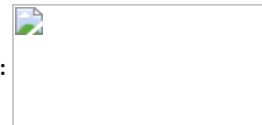
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : AHSAN HUSSAIN

Stamp :



Patient's signature{Parent :
if minor}



27-
Date : Sep-
2024

Signature :

Date : 27-Sep-2024