Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **HYDERALI ALLABAX DUKANDAR**	**Service Date**	**:27-Sep-2024**
Card No	: **I017-029-116122248-02**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**
Policy Holder	: **HYDERALI ALLABAX DUKANDAR**	**Doctor's Name**	**:AHSAN HUSSAIN**
Payer Name	: **ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:
TPA	: **E CARE - Green Network**	**Remarks**	:
Validity	: **01-10-2023** To **30-09-2024**		
Gender	: **Male**		
Date Of Birth	: **24-Dec-1989**		
Patient's Tel No	: **0552906380**		

Network : Green

Direct Access SP - YES

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 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 - Gastro-esophageal reflux disease without esophagitis,R05 - Cough,M54.5 - Low back pain, **Date of Onset** :27/42/2024

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 :

Dr. Ahsan Hussain
General Practitioner
DHA No: 87543658-001
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

Patient 's signature{Parent if minor} :

Date : 27-Sep-2024

Signature :

Date : 27-Sep-2024