Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: HASAN MOHD HAYATH**	**Service Date**	**:27-Jun-2024**	**Network**	**:** Green
Card No	**: I017-029-119768244-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**		**Direct Access SP - YES**
Policy Holder	**: HASAN MOHD HAYATH**	**Doctor's Name**	**:Enomen Goodluck**		
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	**: 15-Mar-2000**				
Patient's Tel No	**: +97470826887**				

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 : Vesicular and hyperemic rash on the right side of the back only (dermatomal). **Duration:**

Vitals: Temp : 36.7 Bp :103 Pulse :63 Resp :18

Clinical Findings:

Diagnosis: B00.9 - Herpesviral infection, unspecified,R52 - Pain, unspecified,L29.9 - Pruritus, unspecified,L20.9 - Atopic dermatitis, unspecified, **Date of Onset** :28/02/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0005-119803-1171 - (PREDNISOLONE : 20 MG) TABLETS,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,1162-347205-1171 - (ACICLOVIR : 400 MG) 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 : Enomen Goodluck **Stamp :**

Dr. Enomen Goodluck Ekata
General Practitioner
DHA No: 28040827-001
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

Patient 's signature{Parent if minor} : **Date :** 28-Jun-2024

Signature : **Date** : 28-Jun-2024