

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name

: GABRIEL COLLACO FREDY

Card No

: I017-029-116125960-02

Policy Holder

: GABRIEL COLLACO FREDY

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

: 02-Mar-1965

Patient's Tel No

: 0528381796

Service Date

:28-Jun-2024

Health Provider

:CITICARE MEDICAL CENTER LLC

Doctor's Name

:Enomen Goodluck

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: Chest pain. A known hypertensive, claims to be compliant with medications. but BP at presentation today is 162/105mmhg (elevated). ECG is advised.

Vitals

:Temp : 36.9 Bp :162 Pulse :83 Resp :18

Clinical Findings:

Diagnosis

: I10 - Essential (primary) hypertension,R07.9 - Chest pain, unspecified,

Date of Onset

: 28/20/2024

Requested Investigations

: 93000, ELECTROCARDIOGRAM COMPLETE,84484, TROPONIN QUANTITATIVE,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIRNTL WBC COUNT,96365, IV INFUSION THERAPY -Antibiotics & Others,96372, INJECTION SERVICE-IM,9, Consultation GP

Estimated Cost

:

Prescriptions:

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.

Dr's Name

: Enomen Goodluck

Stamp

Dr. Enomen Goodluck Ekata

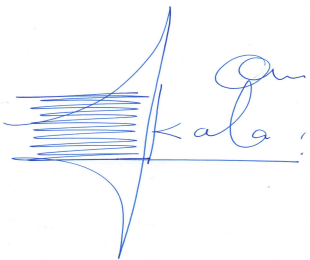
General Practitioner

DHA No: 28040827-001

CITICARE MEDICAL CENTER LLC

DUBAI - U.A.E.

Signature



Date

: 28-Jun-2024

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.

Patient 's signature{Parent : if minor}



Date

: Jun-2024