

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : DALIP SINGH UMESH SINGH Service Date : 02-Jul-2024 Network : Green
Card No : I017-029-119293445-01 Health Provider : CITICARE MEDICAL CENTER LLC Direct Access SP - YES
Policy Holder : DALIP SINGH UMESH SINGH Doctor's Name : Enomen Goodluck
Payer Name : ABU DHABI NATIONAL Co-Insurance :

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

TPA : E CARE - Green Network Remarks :
Validity : 01-10-2023 To 30-09-2024
Gender : Male
Date Of Birth : 20-Jun-1995
Patient's Tel No : 0502052706

☐ Acute ☐ Pre-existing and chronic ☐ Maternity

Chief Complaints : PC: LOWER BACK PAIN 1 WEEK Duration :

Vitals:Temp : 37 Bp :122 Pulse :66 Resp :18

Clinical Findings:

Diagnosis: M54.5 - Low back pain, Date of Onset : 02/15/2024

Requested Investigations: 0005-149902-1021, CLOFEN ,9, Consultation GP,96372, THER/PROPH/DIAG INJ SC/IM

Estimated Cost :

Prescriptions: 4179-711202-0391 - (IBUPROFEN (AS L-ARGININE SALT) : 400 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 :

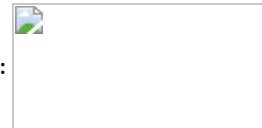
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Enomen Goodluck

Stamp :



Patient 's signature{Parent : if minor}



Date : Jul-2024

Signature :

Date : 02-Jul-2024