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 INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:		
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**				

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: 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 :**

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 :** 02-Jul-2024

Signature : **Date** : 02-Jul-2024