

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name

: NABIL AHMED SHAIKH

Card No

: I017-029-119467325-01

Policy Holder

: NABIL AHMED SHAIKH

Payer Name

: ABU DHABI NATIONAL

TPA

: E CARE - Green Network

Validity

: 01-10-2023 To 30-09-2024

Gender

: Male

Date Of Birth

: 09-Jul-2000

Patient's Tel No

: 0589235069

Service Date

: 02-Jul-2024

Health Provider

: CITICARE MEDICAL CENTER LLC

Doctor's Name

: Enomen Goodluck

Co-Insurance

Remarks

:

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: PAIN NECK THAT COMES TO LEFT ARM MILD PAIN ONLY WHILE WALKING

Duration:

2 WEEKS

Vitals

:Temp : 36.5 Bp :116 Pulse :78 Resp :20

Clinical Findings:

Diagnosis:

M79.603 - Pain in arm, unspecified,R52 - Pain, unspecified,

Date of Onset

: 02/06/2024

Requested Investigations:

0005-149902-1021, CLOFEN ,96372, THER/PROPH/DIAG INJ SC/IM,9,

Estimated Cost

:

Consultation GP

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

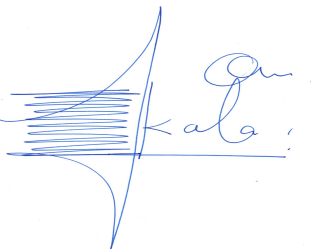
General Practitioner

DHA No: 28040827-001

CITICARE MEDICAL CENTER LLC

DUBAI - U.A.E.

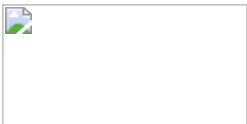
Signature :



Date

: 02-Jul-2024

Patient 's signature{Parent : if minor}



Date

: Jul-2024