Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **NABIL AHMED SHAIKH NISAR AHMAD SHAIKH**	**Service Date**	**:02-Jul-2024**
Card No	: **I017-029-119467325-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**
Policy Holder	: **NABIL AHMED SHAIKH NISAR AHMAD SHAIKH**	**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	: **09-Jul-2000**		
Patient's Tel No	: **0589235069**		

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, Consultation GP **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