Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: ANTON SITHUM CHATHURANGA JAYAMAHA MUDALIGE DON	**Service Date**	:03-Jul-2024
Card No	: I017-029-118774237-01	**Health Provider**	:CITICARE MEDICAL CENTER LLC
Policy Holder	: ANTON SITHUM CHATHURANGA JAYAMAHA MUDALIGE DON	**Doctor's Name**	:Humaira
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	: 27-Jun-2000		
Patient's Tel No	: 0524799560		

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 : co white skin patches on both legs 15 june 2024 oe white patches on the skin spreading all over the body chest is clear no added sounds stable **Duration:**

Vitals: Temp : 36.2 Bp :116 Pulse :68 Resp :18

Clinical Findings:

Diagnosis: R21 - Rash and other nonspecific skin eruption,L24.9 - Irritant contact dermatitis, unspecified cause, **Date of Onset :**03/26/2024

Requested Investigations: 9, Consultation GP **Estimated Cost :**

Prescriptions: **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.

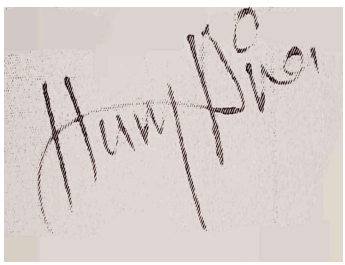
PATIENT'S DECLARATION :

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 : Humaira **Stamp :**

Dr. Humaira Mumtaz
General Practitioner
DHA No: 54155530-002
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

Patient 's signature{Parent if minor} : **Date :** 03-Jul-2024

Signature :  **Date** : 03-Jul-2024