

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: HASAN MOHD HAYATH	Service Date	:04-Jul-2024	Network	: Green														
Card No	: I017-029-119768244-01	Health Provider	:CITICARE MEDICAL CENTER LLC	Direct Access SP - YES															
Policy Holder	: HASAN MOHD HAYATH	Doctor's Name	:Enomen Goodluck																
Payer Name	ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC	Co-Insurance	<table><tr><td>CONSULTATION</td><td>LAB/RADIOLOGY</td><td>PHYSIO</td><td>PHARMACY</td><td>IP</td><td>MATERNITY</td><td>DENTAL</td></tr><tr><td>10% max</td><td>NIL</td><td>NIL</td><td>NIL LIMIT</td><td>NIL</td><td>10%</td><td>NA</td></tr></table>			CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL	10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA
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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	: 15-Mar-2000																		
Patient's Tel No	: +97470826887																		

☐ Acute

☐ Pre-existing and chronic

☐ Maternity

Chief Complaints : PC PAIN LOWER ABDOMEN 1 DAY PAIN STARTED JUST AFTER THE URINATIONDuration:

Vitals:Temp : 36.5 Bp :124 Pulse :76 Resp :18

Clinical Findings:

Diagnosis: R10.84 - Generalized abdominal pain,R10.30 - Lower abdominal pain, unspecified,Date of Onset :04/58/2024

Requested Investigations: 0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML)Estimated Cost :
SOLUTION FOR INJECTION,9.01, Follow Up Consultation GP,96372, THER/PROPH/DIAG INJ SC/IM

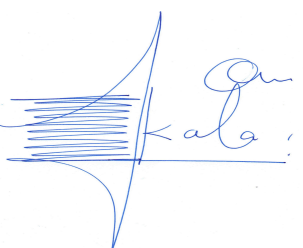
Prescriptions: 4179-711202-0391 - (IBUPROFEN (AS L-ARGININE SALT) : 400 MG) FILM COATED TABLETS,Estimated Cost :

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.

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 : 04-Jul-2024

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.

Patient 's signature{Parent : if minor}



Date : Jul-2024