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**	:		
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**				

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 LOWER ABDOMEN 1 DAY PAIN STARTED JUST AFTER THE URINATION **Duration:**

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) SOLUTION FOR INJECTION,9.01, Follow Up 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.

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 :** 04-Jul-2024