Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: MYO THET TUN**	**Service Date**	**:05-Jul-2024**
Card No	**: I017-029-120534165-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**
Policy Holder	**: MYO THET TUN**	**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	**: 02-Dec-1999**		
Patient's Tel No	**: 0558818406**		

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 nose bleeding on and off without trauma epigastric pain on and off 4 june **Duration:** 2024 oe epigastric pain severe chest is clear no added sound restless

Vitals: Temp : 36.8 Bp :132 Pulse :70 Resp :18

Clinical Findings:

Diagnosis: R04.0 - Epistaxis,K29.70 - Gastritis, unspecified, without bleeding,R10.13 - Epigastric pain, **Date of Onset :**05/10/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0207-533801-1451 - (ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) CAPSULES (HARD GELATIN), **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.

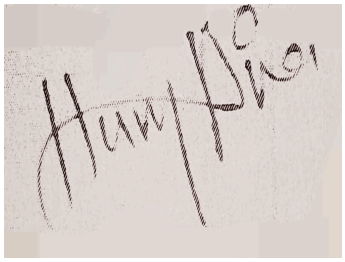
Dr's Name : Humaira

Stamp :

Patient 's signature{Parent if minor} :

Date : 05-Jul-2024

Signature :



Date : 05-Jul-2024