Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: CHAN THAR WIN**	**Service Date**	**:06-Jul-2024**
Card No	**: I017-029-118780637-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**
Policy Holder	**: CHAN THAR WIN**	**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	**: 23-Nov-2002**		
Patient's Tel No	**: 0589232011**		

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: EYE SWELLING/REDNESS UPPER EYE LID 1 DAY **Duration :**

Vitals: Temp : 36.6 Bp :110 Pulse :80 Resp :18

Clinical Findings:

Diagnosis: H02.34 - Blepharochalasis left upper eyelid, **Date of Onset** : 06/12/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0006-106601-0392 - (PARACETAMOL : 500 MG) FILM COATED TABLETS,0139-116207-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 500 MG) 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.

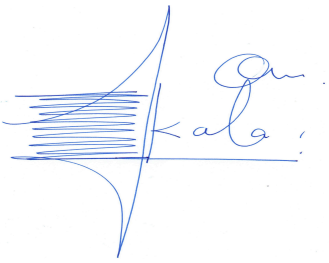
Dr's Name : Enomen Goodluck **Stamp :**

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 : 06-Jul-2024

Signature :



Date : 06-Jul-2024