

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : DALIP SINGH UMESH SINGH Service Date : 06-Jul-2024 Network : Green
Card No : I017-029-119293445-01 Health Provider : CITICARE MEDICAL CENTER LLC Direct Access SP - YES
Policy Holder : DALIP SINGH UMESH SINGH Doctor's Name : Enomen Goodluck
Payer Name : ABU DHABI NATIONAL Co-Insurance :

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
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 : 20-Jun-1995
Patient's Tel No : 0502052706

☐ Acute	☐ Pre-existing and chronic	☐ Maternity
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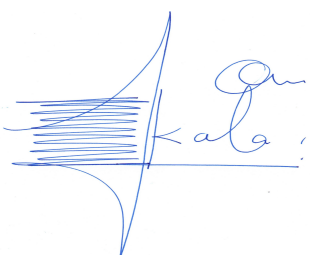
Chief Complaints : PC: PAIN LOWER BACK AND PAIN GOES TO RIGHT LEG SEEMS SCIATICA 7 DAYS Duration: :
Vitals:Temp : 37.3 Bp :126 Pulse :84 Resp :18
Clinical Findings:
Diagnosis: M54.31 - Sciatica, right side,M54.5 - Low back pain, Date of Onset : 06/45/2024
Requested Investigations: 0005-149902-1021, CLOFEN ,9.01, Follow Up Consultation GP,96372, THER/PROPH/DIAG INJ SC/IM Estimated Cost :
Prescriptions: 0207-533801-1451 - (ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) CAPSULES (HARD GELATIN),4417-711202-0391 - (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.	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.
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Dr's Name : Enomen Goodluck

Stamp :

Dr. Enomen Goodluck Ekata General Practitioner DHA No: 28040827-001 CITICARE MEDICAL CENTER LLC DUBAI - U.A.E.
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Signature : 

Date : 06-Jul-2024

Patient's signature{Parent : if minor} 

Date : Jul-2024