

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : KHAING SU MYAT HTWE

Card No : I017-029-120076122-01

Policy Holder : KHAING SU MYAT HTWE

Payer Name : ABU DHABI NATIONAL
INSURANCE COMPANY-
ADNIC

TPA : E CARE - Green Network

Validity : 01-10-2023 To 30-09-2024

Gender : Female

Date Of Birth : 10-Oct-2000

Patient's Tel No : 0523261603

Service Date : 13-Jul-2024

Health Provider : CITICARE MEDICAL CENTER LLC

Doctor's Name : Enomen Goodluck

Co-Insurance :

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

Network : Green

Direct Access SP - YES

Remarks :

☐ Acute☐ Pre-existing and chronic☐ MaternityChief Complaints : PC: PAIN IN FEET 1 DAY REDNES SWELLING ON BOTH FEET LATERAL SIDE 3
DAYS

Vitals:Temp : 36.6 Bp :102 Pulse :73 Resp :18

Clinical Findings:

Diagnosis: R52 - Pain, unspecified,R22.40 - Localized swelling, mass and lump, unspecified lower limb, Date of Onset :13/56/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0195-149901-1771 - (DICLOFENAC SODIUM : 1%) GEL (EMULSION),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.

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

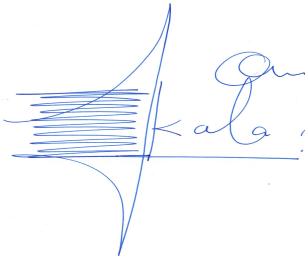
Stamp :

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

Patient's signature{Parent :
if minor}

13-Jul-2024

Signature :



Date : 13-Jul-2024