Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: KHAING SU MYAT HTWE**	**Service Date**	**:13-Jul-2024**	**Network**	**: Green**
Card No	**: I017-029-120076122-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**		**Direct Access SP - YES**
Policy Holder	**: KHAING SU MYAT HTWE**	**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	**: Female**				
Date Of Birth	**: 10-Oct-2000**				
Patient's Tel No	**: 0523261603**				

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 IN FEET 1 DAY REDNES SWELLING ON BOTH FEET LATERAL SIDE 3 DAYS **Duration:**

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} : **Date :** 13-Jul-2024

Signature : **Date** : 13-Jul-2024