

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : CAESAR ZALUM MALLILLIA Service Date :13-Jul-2024 Network : Green
Card No : I017-029-118816759-01 Health Provider :CITICARE MEDICAL CENTER LLC Direct Access SP - YES
Policy Holder : CAESAR ZALUM MALLILLIA 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 : 28-Aug-1972
Patient's Tel No : 0501397656

☐ Acute ☐ Pre-existing and chronic ☐ Maternity

Chief Complaints : PC: HYPERTENSION REFILL MEDICATION Duration :

Vitals:Temp : 37.1 Bp :120 Pulse :79 Resp :22

Clinical Findings:

Diagnosis: I10 - Essential (primary) hypertension, Date of Onset : 13/05/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Estimated Cost :

Prescriptions: 0252-155401-0391 - (LOSARTAN POTASSIUM : 50 MG) FILM COATED TABLETS,

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 :

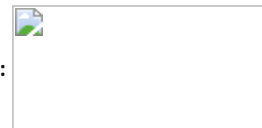
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Enomen Goodluck

Stamp :



Patient 's signature{Parent : if minor}



13-
Date : Jul-
2024

Signature :

Date : 13-Jul-2024