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 INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:		
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**				

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: 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 :**

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