

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name :
AYMAN KHAN KHALID
AKHTAR KHAN

Card No :
I017-029-119448897-01

Policy Holder :
AYMAN KHAN KHALID
AKHTAR KHAN

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 :
29-Dec-1994

Patient's Tel No :
00917412838122

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

☐ Maternity

Chief Complaints : PC: PINK FACE ROSEACCEA Duration :

Vitals:Temp : 3702 Bp :130 Pulse :84 Resp :18

Clinical Findings:

Diagnosis: R21 - Rash and other nonspecific skin eruption, Date of Onset : 13/33/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0195-123701-0391 - CETIRIZINE HCL,0138-169101-1451 - (DOXYCYCLINE : 100 MG) CAPSULES (HARD GELATIN), 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.

Dr's Name : Enomen Goodluck

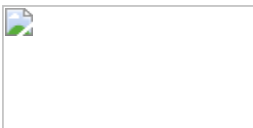
Signature : 

Date : 13-Jul-2024

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.

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 : Jul-2024