Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: AYMAN KHAN KHALID AKHTAR KHAN**	**Service Date**	**:13-Jul-2024**
Card No	**: I017-029-119448897-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**
Policy Holder	**: AYMAN KHAN KHALID AKHTAR KHAN**	**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	**: 29-Dec-1994**		
Patient's Tel No	**: 00917412838122**		

Network : Green

Direct Access SP - YES

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: 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.

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