Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: John Viannie Kajoba	**Service Date**	:17-Jul-2024	**Network**	: Green
Card No	: I017-029-114165333-02	**Health Provider**	:CITICARE MEDICAL CENTER LLC	**Direct Access SP - YES**	
Policy Holder	: John Viannie Kajoba	**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	: 05-Jul-1992				
Patient's Tel No	: 0522262866				

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 : Epigastric and upper abdominal pain that radiates to the central back. There is associated weakness and nausea but has not vomited. Duration: 3days. **Duration:**

Vitals: Temp : 36.9 Bp :126 Pulse :80 Resp :18

Clinical Findings:

Diagnosis: K29.00 - Acute gastritis without bleeding,K85.01 - Idiopathic acute pancreatitis with uninfected necrosis,R10.13 - Epigastric pain, **Date of Onset** :17/31/2024

Requested Investigations: 9, Consultation GP **Estimated Cost** :

Prescriptions: 0042-136501-1173 - (HYOSCINE : 10 MG) TABLETS,0188-232401-0392 - (ESOMEPRAZOLE : 40 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** : 17-Jul-2024

Signature : **Date** : 17-Jul-2024