

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name

DAVEED FRANCIS

: THEKKEVILATHARAYIL VALIYAMALIL JOHN DAVEED

Card No

: I017-029-116524270-02

Policy Holder

DAVEED FRANCIS

: THEKKEVILATHARAYIL VALIYAMALIL JOHN DAVEED

Payer Name

ABU DHABI NATIONAL

: INSURANCE COMPANY-ADNIC

TPA

: E CARE - Green Network

Validity

: 01-10-2023 To 30-09-2024

Gender

: Male

Date Of Birth

: 01-Jun-1961

Patient's Tel No

: 0507647201

Service Date

:18-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

: Chest pain, Duration: 5days. Associated Muscle twitches and spasm, on the chest. Known hypertensive, diabetic and hypercholesterolemia

Duration:

Vitals

:Temp : 36.6 Bp :140 Pulse :68 Resp :22

Clinical Findings:

Diagnosis

: E78.5 - Hyperlipidemia, unspecified,I10 - Essential (primary) hypertension,E11.65 - Type 2 diabetes mellitus with hyperglycemia,R07.9 - Chest pain, unspecified,

Date of Onset

:18/54/2024

Requested Investigations

: 80061, LIPID PANEL,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,83036, HEMOGLOBIN GLYCOSYLATED A1C,82947, GLUCOSE QUANTITATIVE BLOOD XCPT REAGENT STRIP,9, Consultation GP

Estimated Cost

:

Prescriptions

: 0444-348905-0971 - (CHOLECALCIFEROL : 10000 IU) SOFT GELATIN CAPSULES,

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

Stamp :

Dr. Enomen Goodluck Ekata

General Practitioner

DHA No: 28040827-001

CITICARE MEDICAL CENTER LLC

DUBAI - U.A.E.

Signature :

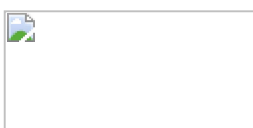


Date : 18-Jul-2024

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.

Patient 's signature{Parent : if minor}



Date : 18-Jul-2024

https://irhamc.visionsoftwares.ae/mr_ecare_claim_print.aspx?appld=49978&patId=27338

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