

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : JANE NANDIWAYA Service Date :24-Jul-2024 Network : Green
Card No : I017-029-117428434-02 Health Provider :CITICARE MEDICAL CENTER LLC Direct Access SP - YES
Policy Holder : JANE NANDIWAYA Doctor's Name :Enomen Goodluck
Payer Name : ABU DHABI NATIONAL Co-Insurance :

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

TPA : E CARE - Green Network Remarks :
Validity : 01-10-2023 To 30-09-2024
Gender : Female
Date Of Birth : 21-Feb-1994
Patient's Tel No : 0526210336

☐ Acute ☐ Pre-existing and chronic ☐ Maternity

Chief Complaints : Whitish vaginal discharge, associated fowl smelling odour. Also has itchy. Duration:

Duration: one month.

Vitals:Temp : 36.6 Bp :128 Pulse :56 Resp :18

Clinical Findings:

Diagnosis: N77.1 - Vaginitis, vulvitis and vulvovaginitis in dis classd elswhr,N39.0 - Urinary tract infection, site not specified,B37.3 - Candidiasis of vulva and vagina, Date of Onset :24/35/2024

Requested Investigations: 9, Consultation GP Estimated Cost :

Prescriptions: 4794-140503-1241 - (CLOTRIMAZOLE : 500 MG) VAGINAL TABLETS,0248-140201-0061 Estimated :
- (FLUCONAZOLE : 150 MG) CAPSULES,0067-116604-0391 - (METRONIDAZOLE : 500 MG) FILM Cost
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 :

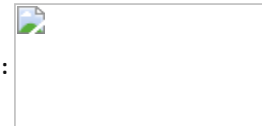
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

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}



24-
Date : Jul-
2024

Signature :

Date : 24-Jul-2024