Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **ASHRAF HASSAN HUSSEIN ELGHAMRY ABOUELGHIT**	**Service Date**	**:27-Jul-2024**	**Network**	: Green
Card No	: **I017-029-116280018-02**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**		**Direct Access SP - YES**
Policy Holder	: **ASHRAF HASSAN HUSSEIN ELGHAMRY ABOUELGHIT**	**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	: **24-Jul-1985**				
Patient's Tel No	: **0547446008**				

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: KNOWN CASE OF ARTHRITIS SVERE PAIN RIGHT AND LEFT FEET JOINTS EPIGASTRIC PAIN GAS COMPLAINT **Duration:**

Vitals: Temp : 37.1 Bp :118 Pulse :47 Resp :18

Clinical Findings:

Diagnosis: E79.0 - Hyperuricemia w/o signs of inflam arthrit and tophaceous dis,K29.00 - Acute gastritis without bleeding,R14.0 - Abdominal distension (gaseous), **Date of Onset** :27/39/2024

Requested Investigations: 0005-149902-1021, CLOFEN ,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,0005-174202-0781, RISEK 40MG-(OMEPRAZOLE : 40 MG) POWDER FOR INFUSION,86431, RHEUMATOID FACTOR QUANTITATIVE,86140, C REACTIVE PROTEIN,85651, SEDIMENTATION RATE RBC NON AUTOMATED,85004, BLOOD COUNT AUTOMATED DIFFERENTIAL WBC COUNT,96372, THER/PROPH/DIAG INJ SC/IM,96365, THER/PROPH/DIAG IV INF INIT,9, Consultation GP **Estimated Cost** :

Prescriptions: 0207-533801-1451 - (ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) CAPSULES (HARD GELATIN),6986-151717-0061 - (SIMETHICONE : 250 MG) 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.

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

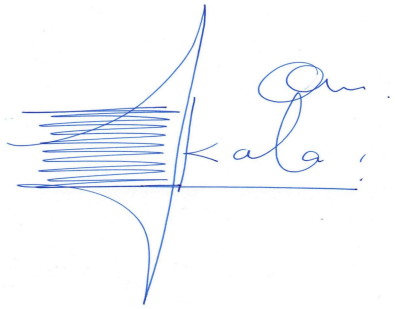
Stamp :

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 : 27-Jul-2024

Signature :



Date : 27-Jul-2024