Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **LALENDRA MAHATO RAM DEV MAHATO**	**Service Date**	**:29-Jul-2024**
Card No	: **I017-029-118012998-02**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**
Policy Holder	: **LALENDRA MAHATO RAM DEV MAHATO**	**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	: **29-May-1994**		
Patient's Tel No	: **0502730793**		

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 : For follow up and wound dressing Had I&D 2nights ago, Has nil fresh complaint. Wound size: 5cm in it's widest axis. Plan: Change wound dressing. **Duration:**

Vitals:

Clinical Findings:

Diagnosis: L02.212 - Cutaneous abscess of back [any part, except buttock],R52 - Pain, unspecified, **Date of Onset** :29/37/2024

Requested Investigations: 51.03, Non-surgical cleansing with surgical dressing more than 48 sq inches / 300 sq centimeters,9.01, Follow Up Consultation GP **Estimated Cost** :

Prescriptions: **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 :** 29-Jul-2024

Signature : **Date** : 29-Jul-2024