

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : LALENDRA MAHATO RAM
DEV MAHATO
Card No : I017-029-118012998-02
Policy Holder : LALENDRA MAHATO RAM
DEV MAHATO
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 : 29-May-1994
Patient's Tel No : 0502730793

Service Date : 29-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 : 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 :

Estimated Cost :
Prescriptions:

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.

PATIENT'S DECLARATION :

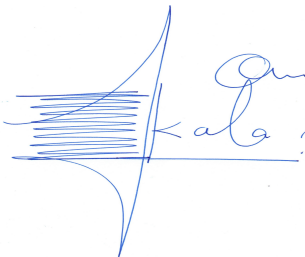
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Patient's signature{Parent : if minor}



29-Jul-2024

Signature :



Date : 29-Jul-2024