

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: LALENDRA MAHATO RAM DEV MAHATO	Service Date	: 31-Jul-2024	Network	: Green														
Card No	: I017-029-118012998-02	Health Provider	: CITICARE MEDICAL CENTER LLC	Direct Access SP	: YES														
Policy Holder	: LALENDRA MAHATO RAM DEV MAHATO	Doctor's Name	: Enomen Goodluck																
Payer Name	: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC	Co-Insurance	<table><tr><td>CONSULTATION</td><td>LAB/RADIOLOGY</td><td>PHYSIO</td><td>PHARMACY</td><td>IP</td><td>MATERNITY</td><td>DENTAL</td></tr><tr><td>10% max</td><td>NIL</td><td>NIL</td><td>NIL LIMIT</td><td>NIL</td><td>10%</td><td>NA</td></tr></table>			CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL	10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA
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	: Male																		
Date Of Birth	: 29-May-1994																		
Patient's Tel No	: 0502730793																		

☐ Acute

☐ Pre-existing and chronic

☐ Maternity

Chief Complaints : For follow up and wound dressing Nil fresh complain. Wound is healing satisfactoritly

Duration:

Vitals:

Clinical Findings:

Diagnosis: L02.212 - Cutaneous abscess of back [any part, except buttock],R52 - Pain, unspecified,

Date of Onset :31/46/2024

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.

Dr's Name : Enomen Goodluck

Stamp :

Dr. Enomen Goodluck Ekata

General Practitioner

DHA No: 28040827-001

CITICARE MEDICAL CENTER LLC

DUBAI - U.A.E.

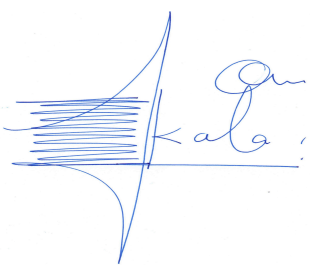
PATIENT'S DECLARATION :

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}



31-Jul-2024

Signature : 

Date : 31-Jul-2024