Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: ABHILASH THAKUR**	**Service Date**	**:01-Aug-2024**
Card No	**: I017-029-120176778-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**
Policy Holder	**: ABHILASH THAKUR**	**Doctor's Name**	**:Enomen Goodluck**
Payer Name	**: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:
TPA	**: E CARE - Green Network**	**Remarks**	**:**
Validity	**: 08-12-2023** To **30-09-2024**		
Gender	**: Male**		
Date Of Birth	**: 26-Nov-1992**		
Patient's Tel No	**: 0561077542**		

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 : PC: Burns injury to the dorsum of the right hand. Exam: Area of the anatomical snuff box only measuring 8cm in the longest axis. Blister and hyperemia is seen. **Duration:**

Vitals: Temp : 36.7 Bp :124 Pulse :60 Resp :18

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,J30.9 - Allergic rhinitis, unspecified,T23.111A - Burn of first degree of right thumb (nail), init encntr,R50.9 - Fever, unspecified, **Date of Onset** :01/37/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 5363-393801-1161 - (DIPHENHYDRAMINE HCL : 13.5 MG/5ML) (AMMONIUM CHLORIDE : 131.5 MG/5 ML) SYRUP,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,2027-560101-0392 - (IBUPROFEN : 150 MG) (PARACETAMOL : 500 MG) FILM COATED TABLETS,0252-185801-0391 - (DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS,0184-122501-0152 - (PANTHENOL : 5%) (SILVER SULFADIAZINE : 1%) CREAM, **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.

Signature :

Date : 01-Aug-2024

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} :

Date : 01-Aug-2024