

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name

: ABHILASH THAKUR

Card No

: I017-029-120176778-01

Policy Holder

: ABHILASH THAKUR

Payer Name

: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC

TPA

: E CARE - Green Network

Validity

: 08-12-2023 To 30-09-2024

Gender

: Male

Date Of Birth

: 26-Nov-1992

Patient's Tel No

: 0561077542

Service Date

:01-Aug-2024

Health Provider

:CITICARE MEDICAL CENTER LLC

Doctor's Name

:Enomen Goodluck

Co-Insurance

Remarks

:

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

Requested Investigations

: 9, Consultation GP

Estimated Cost

:

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 :

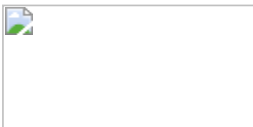


Date : 01-Aug-2024

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}



01-Aug-2024