

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name

: HRIDAY WADHWA KAMAL
HARIRAM WADHWA

Card No

: I017-029-120176865-01

Policy Holder

: HRIDAY WADHWA KAMAL
HARIRAM WADHWA

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

: 26-Mar-1999

Patient's Tel No

: 0522715010

Service Date

:02-Aug-2024

Health Provider

:CITICARE MEDICAL CENTER LLC

Doctor's Name

:Enomen Goodluck

Co-Insurance

Network

: Green

Direct Access SP

- YES

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

Remarks

:

☐ Acute

☐ Pre-existing and chronic

☐ Maternity

Chief Complaints

: PC: PAIN JAW TMJ

Duration

:

Vitals

:Temp : 36.9 Bp :100 Pulse :86 Resp :18

Clinical Findings:

Diagnosis

: R68.84 - Jaw pain,

Date of Onset

: 02/35/2024

Requested Investigations

: 0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML)
SOLUTION FOR INJECTION,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP

Estimated Cost

:

Prescriptions

: 0027-266002-1171 - (TIZANIDINE : 2 MG) TABLETS,4179-711202-0391 - (IBUPROFEN
(AS L-ARGININE SALT) : 400 MG) FILM COATED TABLETS,

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

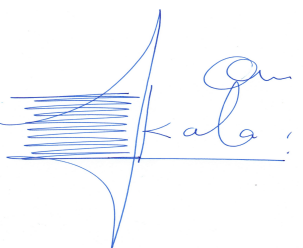
DHA No: 28040827-001

CITICARE MEDICAL CENTER LLC

DUBAI - U.A.E.

Signature

:



Date

: 02-Aug-2024

Patient 's signature{Parent : if minor}

:



Date

: Aug-2024