Administrative **MEDICAL CLAIM FORM** **Claim Ref:**

Patient Name	: John Viannie Kajoba	**Service Date**	:02-Aug-2024	**Network**	: Green
Card No	: I017-029-114165333-02	**Health Provider**	:CITICARE MEDICAL CENTER LLC	**Direct Access SP - YES**	
Policy Holder	: John Viannie Kajoba	**Doctor's Name**	:Enomen Goodluck		
Payer Name	: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC	**Co-Insurance**	:		
TPA	: E CARE - Green Network	**Remarks**	:		
Validity	: 01-10-2023 To 30-09-2024				
Gender	: Male				
Date Of Birth	: 05-Jul-1992				
Patient's Tel No	: 0522262866				

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 : **Duration** :

Vitals:

Clinical Findings:

Diagnosis: Z00.00 - Encntr for general adult medical exam w/o abnormal findings, **Date of Onset** :03/13/2024

Estimated Cost :

Requested Investigations: 10008, ECG,9, Consultation GP

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.

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.

Patient 's signature{Parent if minor} :

Date : 03-Aug-2024

Signature :

Date : 03-Aug-2024