

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : CHAN THAR WIN
Card No : I017-029-118780637-01
Policy Holder : CHAN THAR WIN
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 : 23-Nov-2002
Patient's Tel No : 0589232011

Service Date :03-Aug-2024
Health Provider :CITICARE MEDICAL CENTER LLC
Doctor's Name :Enomen Goodluck
Network : Green
Direct Access SP - YES

Co-Insurance	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: EYELID SWELLING **Duration** :

Vitals:Temp : 37 Bp :96 Pulse :76 Resp :20

Clinical Findings:

Diagnosis: H02.34 - Blepharochalasis left upper eyelid,R50.9 - Fever, unspecified, **Date of Onset** :03/07/2024

Requested Investigations: 0005-107704-0802, TRIAXONE I.V.-(CEFTRIAXONE : 1 G) POWDER FOR INJECTION,96365, THER/PROPH/DIAG IV INF INIT,9, Consultation GP

Estimated Cost :

Prescriptions: 0139-116206-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS,0006-106601-0394 - (PARACETAMOL : 500 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 :

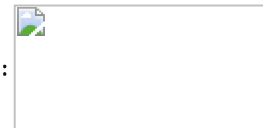
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Enomen Goodluck

Stamp :



Patient's signature{Parent : if minor}



Date : Aug-2024

Signature :

Date : 03-Aug-2024