Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: MYO THET TUN	**Service Date**	:04-Aug-2024	**Network**	: Green
Card No	: I017-029-120534165-01	**Health Provider**	:CITICARE MEDICAL CENTER LLC	**Direct Access SP - YES**	
Policy Holder	: MYO THET TUN	**Doctor's Name**	:Humaira		
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	: 02-Dec-1999				
Patient's Tel No	: 0558818406				

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 : co prulant eye discharge 2nd august 2024 oe prulant discharge from both eye giving him hot efffect restless **Duration:**

Vitals: Temp : 36.6 Bp :130 Pulse :66 Resp :18

Clinical Findings:

Diagnosis: H10.023 - Other mucopurulent conjunctivitis, bilateral,R52 - Pain, unspecified, **Date of Onset** :04/46/2024

Requested Investigations: 9, Consultation GP **Estimated Cost** :

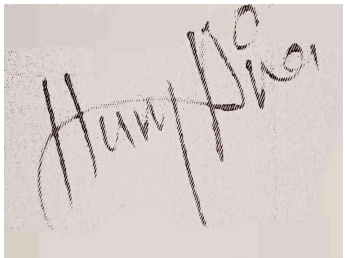
Prescriptions: 0031-237402-0371 - (OFLOXACIN : 0.3%) EYE DROPS,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS, **Estimated Cost** :

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.

Dr's Name : Humaira **Stamp :**

Dr. Humaira Mumtaz
General Practitioner
DHA No: 54155530-002
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

Signature :  **Date** : 04-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 :** 04-Aug-2024