Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: DHAN KUMAR GURUNG**	**Service Date**	**:08-Aug-2024**	**Network**	**: Green**
Card No	**: I017-029-120988564-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**		**Direct Access SP - YES**
Policy Holder	**: DHAN KUMAR GURUNG**	**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	**: 02-Jan-1998**				
Patient's Tel No	**: 0508678168**				

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: EYE REDNESS CONJUCTIVITIS **Duration :**

Vitals: Temp : 36.1 Bp :103 Pulse :55 Resp :18

Clinical Findings:

Diagnosis: H10.12 - Acute atopic conjunctivitis, left eye, **Date of Onset** : 08/27/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0195-123701-0391 - CETIRIZINE HCL,0049-113202-0371 - (BRIMONIDINE TARTRATE : 0.15%) EYE DROPS, **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** : 08-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 :** 08-Aug-2024