Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: NADEEM AHMAD SALIM KHAN**
Card No	**: I011-029-119557476-02**
Policy Holder	**: NADEEM AHMAD SALIM KHAN**
Payer Name	**: AL SAGR NATIONAL INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 19-06-2024** To **18-06-2025**
Gender	**: Male**
Date Of Birth	**: 20-Feb-1983**
Patient's Tel No	**: 0554951623**

Service Date :10-Aug-2024 **Network** : Green

Health Provider **:CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**

Doctor's Name **:Enomen Goodluck**

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: pain and redness of the right eye Duration: 2 days associated itching. **Duration :**

Vitals: Temp : 36.5 Bp :130 Pulse :89 Resp :18

Clinical Findings:

Diagnosis: B30.8 - Other viral conjunctivitis,H10.11 - Acute atopic conjunctivitis, right eye,L29.8 - Other pruritus, **Date of Onset:**10/29/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0696-148701-1172 - (LORATADINE : 10 MG) TABLETS,0085-232201-0371 - (NEPAFENAC : 0.1%) 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.

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 :** 10-Aug-2024

Signature : **Date** : 10-Aug-2024