Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **KHARAK SINGH KISHAN SINGH**	**Service Date**	**:11-Aug-2024**	**Network**	: Green
Card No	: **I017-029-119076401-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**	**Direct Access SP - YES**	
Policy Holder	: **KHARAK SINGH KISHAN SINGH**	**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	: **15-Jul-1998**				
Patient's Tel No	: **0569469783**				

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 : CONJUCTIVITIS **Duration :**

Vitals: Temp : 36.9 Bp :104 Pulse :84 Resp :18

Clinical Findings:

Diagnosis: M62.81 - Muscle weakness (generalized),R50.9 - Fever, unspecified,R52 - Pain, unspecified,H10.33 - Unspecified acute conjunctivitis, bilateral, **Date of Onset** :11/20/2024

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

Prescriptions: **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.

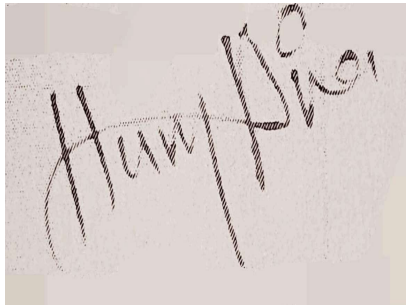
Dr's Name : Humaira

Stamp :

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

Patient 's signature{Parent : if minor}

Date : 11-Aug-2024

Signature : 

Date : 11-Aug-2024