Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **SWAROOP KORTI SALABANNA KORTI**	**Service Date**	**:26-Aug-2024**
Card No	: **I017-029-120763030-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**
Policy Holder	: **SWAROOP KORTI SALABANNA KORTI**	**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	: **17-Jun-2000**		
Patient's Tel No	: **0589418984**		

Network : Green

Direct Access SP - YES

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 : Swelling and pain on the lower lid of the left eye. Duration: 2days. There is also redness on both eyes with itching Exam: periorbital hyperpigmentation of both eyes; suggestive of allergies. **Duration:**

Vitals: Temp : 35.7 Bp :111 Pulse :58 Resp :18

Clinical Findings:

Diagnosis: H00.019 - Hordeolum externum unspecified eye, unspecified eyelid,H10.029 - Other mucopurulent conjunctivitis, unspecified eye,J30.9 - Allergic rhinitis, unspecified, **Date of Onset** :26/01/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0085-387501-0241 - (HYDROCORTISONE : 10 MG/ML) (CIPROFLOXACIN (AS HYDROCHLORIDE) : 2 MG/ML) EAR DROPS,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,2027-560101-0392 - (IBUPROFEN : 150 MG) (PARACETAMOL : 500 MG) FILM COATED TABLETS,0139-116207-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 500 MG) TABLETS, **Estimated Cost** :

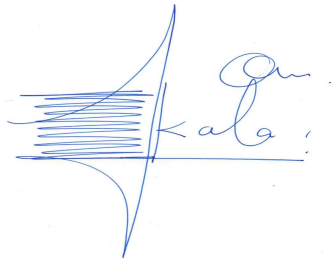
MEDICAL PRACTITIONER DECLARATION :

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 : Enomen Goodluck

Stamp :

Dr. Enomen Goodluck Ekata
General Practitioner
DHA No: 28040827-001
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

Signature : 

Date : 26-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 : 26-Aug-2024