## Administrative MEDICAL CLAIM FORM Claim Ref:

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|---|---|---|---|---|---|
| **Patient Name** | **: SONAM TAMANG** | **Service Date** | **:31-Aug-2024** | **Network** | **: Green** |
| **Card No** | **: I017-029-120831151-01** | **Health Provider** | **:CITICARE MEDICAL CENTER LLC** | | **Direct Access SP - YES** |
| **Policy Holder** | **: SONAM TAMANG** | **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** | **: 11-Mar-1999** | | | | |
| **Patient's Tel No** | **: 0563505195** | | | | |

| 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 :** Highly pruritic lesions of the skin anterior knee joint and associated exfoliation of the skin. **Duration:**

**Vitals:**Temp : 37 Bp :115 Pulse :75 Resp :18

**Clinical Findings:**

**Diagnosis:** L40.9 - Psoriasis, unspecified,L30.9 - Dermatitis, unspecified,L29.8 - Other pruritus, **Date of Onset :**31/23/2024

**Estimated Cost :**

**Requested Investigations:** 9, Consultation GP

**Prescriptions:** 1111-183201-0391 - (FEXOFENADINE HCL : 120 MG) FILM COATED TABLETS,0009-149801-0151 - (CLOBETASOL PROPIONATE : 0.05%) CREAM,0005-119803-1171 - (PREDNISOLONE : 20 MG) TABLETS,0070-310402-1021 - (BETAMETHASONE SODIUM PHOSPHATE : 5.26MG/2ML) (BETAMETHASONE DIPROPIONATE : 12.56MG/2ML) SOLUTION FOR INJECTION, **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 :** 31-Aug-2024

**Signature :** **Date** : 31-Aug-2024