Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **ABHISHEK KUMAR VINAY KUMAR SINGH**	**Service Date**	**:09-Sep-2024**	**Network**	**:** Green
Card No	: **I017-029-119959937-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**		**Direct Access SP - YES**
Policy Holder	: **ABHISHEK KUMAR VINAY KUMAR SINGH**	**Doctor's Name**	**:Enomen Goodluck**		
Payer Name	: **ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:		
TPA	: **E CARE - Green Network**	**Remarks**	:		
Validity	: **09-10-2023** To **30-09-2024**				
Gender	: **Male**				
Date Of Birth	: **05-Mar-2002**				
Patient's Tel No	: **971528501605**				

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 : Fever, low back pain, cough Duration: 2days **Duration :**

Vitals: Temp : 37 Bp :139 Pulse :92 Resp :0

Clinical Findings:

Diagnosis: M54.5 - Low back pain, **Date of Onset** : 09/36/2024

Requested Investigations: 96372, THER/PROPH/DIAG INJ SC/IM,0005-149902-1021, CLOFEN ,9.01, Follow Up Consultation GP **Estimated Cost :**

Prescriptions: 0027-142201-0831 - (DICLOFENAC POTASSIUM : 50 MG) POWDER FOR SOLUTION, **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 :** 09-Sep-2024

Signature : **Date** : 09-Sep-2024