Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: EL NANDAR KYAW**	**Service Date**	**:11-Sep-2024**	**Network**	**: Green**
Card No	**: I017-029-120111934-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**		**Direct Access S**
Policy Holder	**: EL NANDAR KYAW**	**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	**: Female**				
Date Of Birth	**: 19-Dec-1999**				
Patient's Tel No	**: 0522649643**				

CONSULTATION	LAB/ RADIOLOGY	PHYSIO	PHARMACY	IP	MATEF
10% max	NIL	NIL	NIL LIMIT	NIL	10%

☐ **Acute** ☐ **Pre-existing and chronic** ☐ **Maternity**

Chief Complaints : Diarrhea: that is green in colour and fowl smelling. There is no fever however. **Duration:**

Vitals: Temp : 37 Bp :99 Pulse :72 Resp :22

Clinical Findings:

Diagnosis: A09 - Infectious gastroenteritis and colitis, unspecified,R19.7 - Diarrhea, unspecified,K29.00 - Acute gastritis without bleeding, **Date of Onset**

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0135-116604-1171 - (METRONIDAZOLE : 500 MG) TABLETS,0137-242801-0341 - (PANTOPRAZOLE (AS SODIUM) : 20 MG) ENTERIC COATED 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.

PATIENT'S DECLARATION :

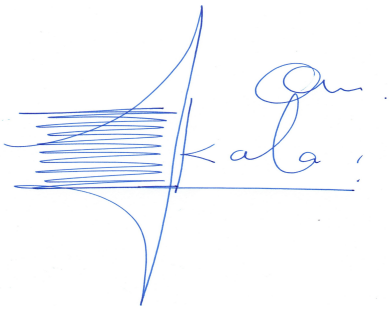
I hereby authorize any Healthcar or other organization to release a medical condition & history for p insurance benefits.

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}

Signature :  **Date** : 11-Sep-2024