Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **JIBIN SEBASTIAN SIBI NEENDOOR GEORGE**	**Service Date**	**:17-Sep-2024** **Network** : Green
Card No	: **I017-029-119379227-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **JIBIN SEBASTIAN SIBI NEENDOOR GEORGE**	**Doctor's Name**	**:AHSAN HUSSAIN**
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	: **14-Jul-1997**		
Patient's Tel No	: **0509337531**		

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 : PC: EAR BLOCKAGE DUE TO WAX PAIN IN EAR **Duration :**

Vitals: Temp : 36.5 Bp :122 Pulse :66 Resp :18

Clinical Findings:

Diagnosis: H61.23 - Impacted cerumen, bilateral,H60.513 - Acute actinic otitis externa, bilateral,R52 - Pain, unspecified, **Date of Onset** :17/43/2024

Requested Investigations: 9, Consultation GP,0005-149902-1021, CLOFEN ,96372, THER/PROPH/DIAG INJ SC/IM **Estimated Cost** :

Prescriptions: 4179-711202-0391 - (IBUPROFEN (AS L-ARGININE SALT) : 400 MG) FILM COATED TABLETS,0609-280801-0241 - PHENAZONE, **Estimated Cost** :

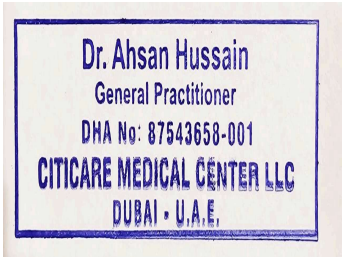
MEDICAL PRACTITIONER DECLARATION :

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 :

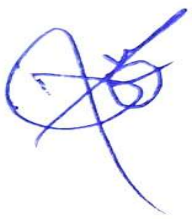
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : AHSAN HUSSAIN **Stamp :**



Patient 's signature{Parent if minor} : **Date :** 17-Sep-2024

Signature :



Date : 17-Sep-2024