Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: WAQAR AHMED MOHD ASLAM	**Service Date**	:17-Sep-2024	**Network**	: Green
Card No	: I017-029-119050823-01	**Health Provider**	:CITICARE MEDICAL CENTER LLC		**Direct Access S**
Policy Holder	: WAQAR AHMED MOHD ASLAM	**Doctor's Name**	:Enomen Goodluck		
Payer Name	: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC	**Co-Insurance**	:		
TPA	: E CARE - Green Network				
Validity	: 01-10-2023 To 30-09-2024				
Gender	: Male	**Remarks**	:		
Date Of Birth	: 15-Jan-1998				
Patient's Tel No	: 0545734696				

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

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

Chief Complaints : Swelling and severe pain on the finger bed of the right ring finger Duration 10days Exam: cystic with pus spot over it. **Duration:**

Vitals: Temp : 36 Bp :110 Pulse :84 Resp :18

Clinical Findings:

Diagnosis: L03.011 - Cellulitis of right finger,A49.9 - Bacterial infection, unspecified, **Date of Onset :**

Requested Investigations: 10061, INCISION&DRAINAGE ABSCESS COMPLICATED/MULTIPLE,96372, THER/PROPH/DIAG INJ SC/IM,0005-149902-1021, CLOFEN ,9, Consultation GP **Estimated Cost :**

Prescriptions: 0067-116604-0391 - (METRONIDAZOLE : 500 MG) FILM COATED TABLETS,0139-116206-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS,0027-149903-0111 - (DICLOFENAC SODIUM : 100 MG) 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 :

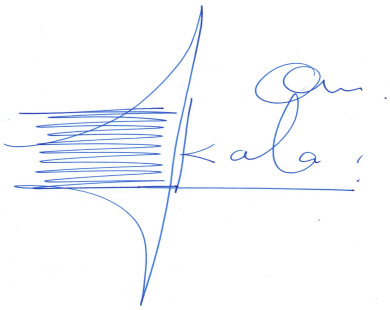
I hereby authorize any Healthcar or other organization to release a medical condition & history for p insurance benefits.

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** : 17-Sep-2024