

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name

: OLINDA SOFIA WISANTRI

Card No

: I017-029-120688211-01

Policy Holder

: OLINDA SOFIA WISANTRI

Payer Name

: ABU DHABI NATIONAL
INSURANCE COMPANY-
ADNIC

TPA

: E CARE - Green Network

Validity

: 16-04-2024 To 30-09-2024

Gender

: Female

Date Of Birth

: 08-Apr-2004

Patient's Tel No

: 0559921789

Service Date

:19-Sep-2024

Health Provider

:CITICARE MEDICAL CENTER LLC

Doctor's Name

:Enomen Goodluck

Co- Insurance

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

Network

: Green

Direct Access SP - YES

☐ Acute

☐ Pre-existing and chronic

☐ Maternity

Chief Complaints

: PC: Nasal congestion, pain in throat, cough and fever. Duration: 3days There Duration:
is no chest pain and no difficulty breathing,

Vitals

:Temp : 37.4 Bp :118 Pulse :87 Resp :18

Clinical Findings:

Diagnosis

: J06.9 - Acute upper respiratory infection, unspecified,J30.9 - Allergic rhinitis, unspecified,R50.9 - Fever, unspecified,
unspecified,

Estimated Cost

:

Requested Investigations

: 9, Consultation GP

Prescriptions

: 0097-127405-0392 - (AZITHROMYCIN : 500 MG) FILM COATED TABLETS,0252-185801-0391 - (DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS,0005-116702-2481 - (DIPHENHYDRAMINE : 12.5 MG/5ML) SYRUP (SUGAR FREE),2027-560101-0392 - (IBUPROFEN : 150 MG) (PARACETAMOL : 500 MG) FILM COATED TABLETS,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM 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.

Dr's Name

: Enomen Goodluck

Stamp

Dr. Enomen Goodluck Ekata

General Practitioner

DHA No: 28040827-001

CITICARE MEDICAL CENTER LLC

DUBAI - U.A.E.

Signature



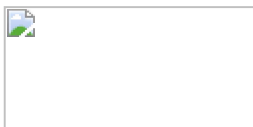
Date

: 19-Sep-2024

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.

Patient 's signature{Parent : if minor}



Date

: Sep-2024

https://irhamc.visionsoftwares.ae/mr_ecare_claim_print.aspx?appld=52930&patId=54285

1/1