Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **MAREENA THISHUNI HIMASHA EDIRISINGHE**	**Service Date**	**:19-Sep-2024**	**Network**	**:** Green
Card No	: **I017-029-120365768-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**	**Direct Access SP - YES**	
Policy Holder	: **MAREENA THISHUNI HIMASHA EDIRISINGHE**	**Doctor's Name**	**:Enomen Goodluck**		
Payer Name	: **ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:		
TPA	: **E CARE - Green Network**	**Remarks**	:		
Validity	: **18-07-2024** To **30-09-2024**				
Gender	: **Female**				
Date Of Birth	: **17-Nov-2001**				
Patient's Tel No	: **0586687403**				

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: Missed period. Weakness and tiredness. LMP is 2nd August, 2024, now a **Duration:** month and 2 weeks late. Also has flu symptoms.

Vitals: Temp : 36.6 Bp :110 Pulse :74 Resp :18

Clinical Findings:

Diagnosis: **Date of Onset** : 20/53/2024

Requested Investigations: 9, Consultation GP **Estimated Cost** :

Prescriptions: **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 :** 20-Sep-2024

Signature : **Date** : 20-Sep-2024