

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name

: MAREENA THISHUNI
HIMASHA EDIRISINGHE

Card No

: I017-029-120365768-01

Policy Holder

: MAREENA THISHUNI
HIMASHA EDIRISINGHE

Payer Name

: ABU DHABI NATIONAL
INSURANCE COMPANY-ADNIC

TPA

: E CARE - Green Network

Validity

: 18-07-2024 To 30-09-2024

Gender

: Female

Date Of Birth

: 17-Nov-2001

Patient's Tel No

: 0586687403

Service Date

:21-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

Remarks

:

☐ Acute

☐ Pre-existing and chronic

☐ Maternity

Chief Complaints

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

Vitals

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

Clinical Findings:

Diagnosis

: J06.9 - Acute upper respiratory infection, unspecified,N91.2 - Amenorrhea, unspecified,J30.9 - Allergic rhinitis, unspecified,

Date of Onset

:21/53/2024

Requested Investigations

: 9, Consultation GP

Estimated Cost

:

Prescriptions:

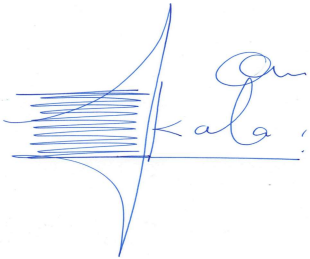
MEDICAL PRACTITIONER DECLARATION :

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

Signature



Stamp

Dr. Enomen Goodluck Ekata

General Practitioner

DHA No: 28040827-001

CITICARE MEDICAL CENTER LLC

DUBAI - U.A.E.

Date

: 21-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

: 21-Sep-2024