Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: HYDERALI ALLABAX DUKANDAR**	**Service Date**	**:28-Sep-2024**	**Network**	**:** Green
Card No	**: I017-029-116122248-02**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**		**Direct Access S**
Policy Holder	**: HYDERALI ALLABAX DUKANDAR**	**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	**: 24-Dec-1989**				
Patient's Tel No	**: 0552906380**				

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

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

Chief Complaints : **Duration :**

Vitals: Temp : 36.2 Bp :95 Pulse :83 Resp :18

Clinical Findings:

Diagnosis: **Date of Onset** **:** 02/56/2024

Estimated Cost :

Requested Investigations: 9.01, Follow Up 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.

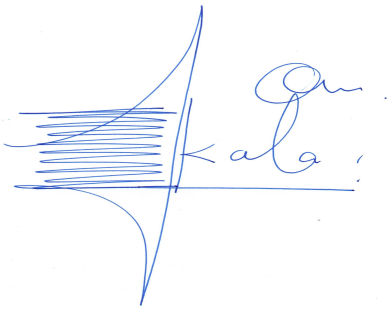
PATIENT'S DECLARATION :

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** : 02-Oct-2024