Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: CHAN THAR WIN	**Service Date**	:28-Sep-2024	**Network**	: Green
Card No	: I017-029-118780637-01	**Health Provider**	:CITICARE MEDICAL CENTER LLC		**Direct Access SP - YES**
Policy Holder	: CHAN THAR WIN	**Doctor's Name**	:AHSAN HUSSAIN		
Payer Name	: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC	**Co-Insurance**	:		
TPA	: E CARE - Green Network	**Remarks**	:		
Validity	: 01-10-2023 To 30-09-2024				
Gender	: Male				
Date Of Birth	: 23-Nov-2002				
Patient's Tel No	: 0589232011				

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 : coEYE SWELLING/REDNESS UPPER EYE LID headache 21th sep. 2024 oe chest is clear no added sounds restless **Duration:**

Vitals: Temp : 36.3 Bp :104 Pulse :67 Resp :18

Clinical Findings:

Diagnosis: H02.34 - Blepharochalasis left upper eyelid,R51.9 - Headache, unspecified, **Date of Onset** :28/54/2024

Requested Investigations: 9.01, Follow Up Consultation GP **Estimated Cost** :

Prescriptions: 0139-116206-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) 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 : AHSAN HUSSAIN **Stamp :**

Dr. Ahsan Hussain
General Practitioner
DHA No: 87543658-001
CITICARE MEDICAL CENTER LLC
DUBAI • U.A.E.

Signature : **Date** : 28-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 :** 28-Sep-2024