

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : CHAN THAR WIN

Card No : I017-029-118780637-01

Policy Holder : CHAN THAR WIN

Payer Name : ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC

TPA : E CARE - Green Network

Validity : 01-10-2023 To 30-09-2024

Gender : Male

Date Of Birth : 23-Nov-2002

Patient's Tel No : 0589232011

Service Date :28-Sep-2024

Health Provider :CITICARE MEDICAL CENTER LLC

Doctor's Name :AHSAN HUSSAIN

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

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

Clinical Findings:

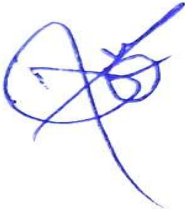
Diagnosis: H02.34 - Blepharochalasis left upper eyelid,R51.9 - Headache, unspecified,      Date of Onset :28/54/2024

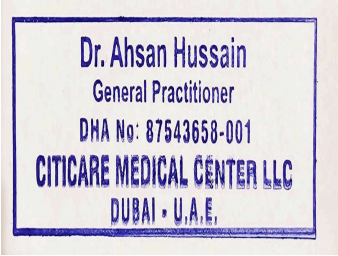
Requested Investigations: 9.01, Follow Up Consultation GP      Estimated Cost :

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

Signature :

Stamp :

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 : Sep-2024