Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **SWAROOP KORTI SALABANNA KORTI**	**Service Date**	**:29-Sep-2024**	**Network**	**:** Green
Card No	: **I017-029-120763030-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**		**Direct Access S**
Policy Holder	: **SWAROOP KORTI SALABANNA KORTI**	**Doctor's Name**	**:Humaira**		
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	: **17-Jun-2000**				
Patient's Tel No	: **0589418984**				

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

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

Chief Complaints : co swelling and pain on the lower lid left eye 26th sep. 2024 oe chest is clear **Duration:** no added sounds restless

Vitals: Temp : 37.2 Bp :110 Pulse :78 Resp :18

Clinical Findings:

Diagnosis: H00.15 - Chalazion left lower eyelid,R52 - Pain, unspecified, **Date of Onset** :29

Requested Investigations: 0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP **Estimated Cost** :

Prescriptions: 0027-142201-0832 - (DICLOFENAC POTASSIUM : 50 MG) POWDER FOR SOLUTION,0085-125903-0372 - (MOXIFLOXACIN (AS HCL) : 0.5%) EYE DROPS, **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 :

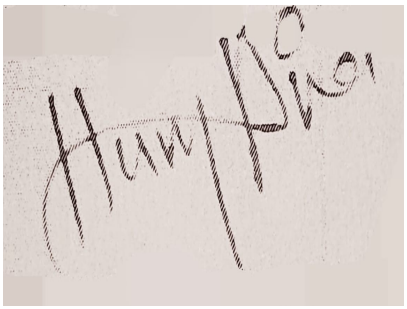
I hereby authorize any Healthcar or other organization to release a medical condition & history for p insurance benefits.

Dr's Name : Humaira

Stamp :

Dr. Humaira Mumtaz
General Practitioner
DHA No: 54155530-002
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

Patient 's signature{Parent : if minor}

Signature :  **Date :** 29-Sep-2024