Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **MANJUSHA ADLAKHA NARAYAN LAL ADLAKHA**	**Service Date:**	**28-Nov-2024**
Card No	: **R6604522**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**
Policy Holder	: **MANJUSHA ADLAKHA NARAYAN LAL ADLAKHA**	**Doctor's Name**	**:Enomen Goodluck**
Payer Name	: **TAKAFUL EMARAT**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **31-07-2024** To **30-07-2025**		
Gender	: **Female**		
Date Of Birth	: **17-Oct-1979**		
Patient's Tel No	: **0523668349**		

Network : Green

Direct Access SP - YES

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 : For follow up Was previously referred by me to the specialist breast surgeon but she went to Aster and the surgeon sent her back to me to request USG guilded FNAC. I cannnot make this specialized procedure request as per insurance policy. Patient is counselled to go another hospital. **Duration:**

Vitals: Temp : 36.5 Bp :110 Pulse :74 Resp :18

Clinical Findings:

Diagnosis: N63.11 - Unspecified lump in the right breast, upper outer quadrant, **Date of Onset** :28/47/2024

Requested Investigations: 9, Consultation GP **Estimated Cost** :

Prescriptions: **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 Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining 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} : **Date** : 28-Nov-2024

Signature : **Date** : 28-Nov-2024