

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name

: SANIA RASHEED

Card No

: I017-029-120848630-01

Policy Holder

: SANIA RASHEED

Payer Name

: ABU DHABI NATIONAL
INSURANCE COMPANY-ADNIC

TPA

: E CARE - Blue Network

Validity

: 24-05-2024 To 30-09-2024

Gender

: Female

Date Of Birth

: 20-Jan-1999

Patient's Tel No

: 0558132736

Service Date

:06-Aug-2024

Health Provider

:CITICARE MEDICAL CENTER LLC

Doctor's Name

:Enomen Goodluck

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 :

Duration :

Vitals:

Clinical Findings:

Diagnosis: J03.90 - Acute tonsillitis, unspecified,J01.40 - Acute pansinusitis, unspecified,R51.9 - Headache, unspecified,R50.9 - Fever, unspecified,N94.4 - Primary dysmenorrhea,

Date of Onset

:06/10/2024

Requested Investigations: 0195-107704-0801, CEFTRIAXONE-TABUK IV,96374, THER/PROPH/DIAG INJ IV PUSH,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.

Dr's Name

: Enomen Goodluck

Signature :



Date

: 06-Aug-2024

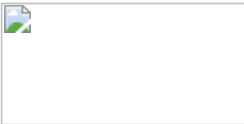
Stamp :

Dr. Enomen Goodluck Ekata
General Practitioner
DHA No: 28040827-001
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

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

: Aug-2024