Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: SANIA RASHEED**	**Service Date**	**:06-Aug-2024**	**Network**	**: Green**
Card No	**: I017-029-120848630-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**		**Direct Access SP - YES**
Policy Holder	**: SANIA RASHEED**	**Doctor's Name**	**:Enomen Goodluck**		
Payer Name	**: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:		
TPA	**: E CARE - Blue Network**	**Remarks**	:		
Validity	**: 24-05-2024** To **30-09-2024**				
Gender	**: Female**				
Date Of Birth	**: 20-Jan-1999**				
Patient's Tel No	**: 0558132736**				

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 : **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: **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 : Enomen Goodluck **Stamp :**

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

Signature : **Date** : 06-Aug-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 :** 06-Aug-2024