Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **PIRAJI CHOUGULE KRISHNA**	**Service Date**	:**29-Jun-2024**
Card No	: **I040-029-120896487-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC**
Policy Holder	: **PIRAJI CHOUGULE KRISHNA**	**Doctor's Name**	:**Enomen Goodluck**
Payer Name	: **UNION INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **06-06-2024** To **01-01-2025**		
Gender	: **Male**		
Date Of Birth	: **14-Sep-2002**		
Patient's Tel No	: **0551975605**		

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 : PC: Recurrent lower abdominal pain. Duration: 2days Pain is dull aching and located in the lower abdomen at the site of previous incision scar on both sides of the abdomen. He was said to have had surgery in childhood for a hydrocele. Pain started since he started working as a house keeper last month. There is no fever and he has no history of trauma. **Duration:**

Vitals: Temp : 36.5 Bp :114 Pulse :76 Resp :18

Clinical Findings:

Diagnosis: K43.2 - Incisional hernia without obstruction or gangrene,R10.30 - Lower abdominal pain, unspecified, **Date of Onset:**29/50/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Estimated Cost :

Prescriptions: 0027-142201-0831 - (DICLOFENAC POTASSIUM : 50 MG) POWDER FOR SOLUTION,

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 : 29-Jun-2024

Signature :

Date : 29-Jun-2024