## **Administrative**

## **MEDICAL CLAIM FORM**

## Claim Ref:

Service Date :01-Jul-2024 Network : Green **Patient** : NAW NOBLE

Health Name :CITICARE MEDICAL CENTER LLC **Direct Access SP - YES** 

Provider **Card No** : 1040-029-120585625-01

Doctor's

Policy Holder: NAW NOBLE

Payer Name : UNION INSURANCE COMPANY

:Enomen Goodluck Name

CONSULTATION LAB/RADIOLOGY PHYSIO PHARMACY IP MATERNITY DENTAL **Co-Insurance** NIL NIL LIMIT ||NIL ||10% 10% max NIL NA

TPA : E CARE - Blue Network

: 02-01-2024 To 01-01-2025

Remarks

Gender : Female Date Of Birth: 22-Oct-1992 Patient's Tel

Validity

: 0555635483

☐ Acute ☐ Pre-existing and chronic			Maternity		
	ing und cirrottic			y	
Chief Complaints: Recurrent rash on t	he elbow of the righ	nt upper limb. Also severe pain on	the <b>Duration</b> :		
elbow joint. Said to result after doing v	accum cleaning. Sho	e works at the hotel as housekeepi	ing		
with daily vaccuming. patient is counsl		algesic and take some days rest. De	oes		
not smoke, but take alcohol occasinoal	·				
Vitals:Temp: 36.5 Bp:120 Pulse:76 Re	esp :18				
Clinical Findings:					
Diagnosis: L20.9 - Atopic dermatitis, ur	nspecified,M70.21 -	Olecranon bursitis, right elbow,R5	2 - Pain, unspecified	d, Date of Onset:02/35/2	024
		Estimated Cost	:		
Requested Investigations: 9, Consultat	ion GP				
Prescriptions: 0031-124403-0151 - (M (PREDNISOLONE : 20 MG) TABLETS,111	l1-183201-0391 - (F	EXOFENADINE HCL : 120 MG) FILM		l :	
TABLETS,1516-107902-1171 - (IBUPRO	•	E13,			
MEDICAL PRACTITIONER DECLARATION :			PATIENT'S 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.			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 : Enomen Goodluck Name	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}		02- <b>Date :</b> Jul- 2024
Signature :	9 / <b>Date</b> : 0	2-Jul-2024			