

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : AHMAD . JAMEEL
Card No : I040-029-119282953-01
Policy Holder : AHMAD . JAMEEL
Payer Name : UNION INSURANCE COMPANY
TPA : E CARE - Blue Network
Validity : 30-03-2024 To 29-03-2025
Gender : Male
Date Of Birth : 29-Nov-2001
Patient's Tel No : 0521940156

Service Date :02-Jul-2024
Health :CITICARE MEDICAL CENTER LLC
Provider :Enomen Goodluck
Doctor's Name :

Network : Green
Direct Access SP - YES

Co-Insurance :

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

Remarks :

☐ Acute ☐ Pre-existing and chronic ☐ Maternity

Chief Complaints : PC: FEVER 1 DAY FLU 1 DAY BODY ACHES 1 DAY

Duration :

Vitals:Temp : 36.6 Bp :116 Pulse :72 Resp :18

Clinical Findings:

Diagnosis: R50.9 - Fever, unspecified,J00 - Acute nasopharyngitis [common cold],

Date of Onset :02/54/2024

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,9, Estimated Cost
Consultation GP

Prescriptions: 0070-148701-1171 - (LORATADINE : 10 MG) TABLETS,0005-938301-3381 - (CAFFEINE ANHYDROUS : 25 MG) (PARACETAMOL : 500 MG) (PHENYLEPHRINE HCL : 5 MG) CAPLET-TABLET, 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 :

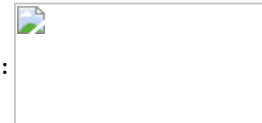
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

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 : Jul-2024

Signature :

Date : 02-Jul-2024