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** **Network** : Green

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

Doctor's Name :**Enomen Goodluck**

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, Consultation GP **Estimated Cost** :

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 : 02-Jul-2024

Signature :

Date : 02-Jul-2024