Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: PIRAJI CHOUGULE KRISHNA**
Card No	**: I040-029-120896487-01**
Policy Holder	**: PIRAJI CHOUGULE KRISHNA**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 06-06-2024** To **01-01-2025**
Gender	**: Male**
Date Of Birth	**: 14-Sep-2002**
Patient's Tel No	**: 0551975605**

Service Date **:05-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 : Dull aching pain in the left groin and lower abdomen. Also pain in the left testicle. Exam: Left scrotal sac feels like a bag of worms. **Duration:**

Vitals: Temp : 37.1 Bp :122 Pulse :77 Resp :18

Clinical Findings:

Diagnosis: I86.1 - Scrotal varices,R52 - Pain, unspecified, **Date of Onset** **:** 05/28/2024

Estimated Cost **:**

Requested Investigations: 9, Consultation GP

Prescriptions: 2027-560101-0392 - (IBUPROFEN : 150 MG) (PARACETAMOL : 500 MG) FILM COATED TABLETS, **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 :** 05-Jul-2024

Signature : **Date** **:** 05-Jul-2024