Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **ABDUL GHAFFAR MUNIR AHMAD**	**Service Date**	:**05-Jul-2024**
Card No	: **I040-029-120695866-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC**
Policy Holder	: **ABDUL GHAFFAR MUNIR AHMAD**	**Doctor's Name**	:**Enomen Goodluck**
Payer Name	: **UNION INSURANCE COMPANY**	**Co-Insurance**	
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **30-03-2024** To **29-03-2025**		
Gender	: **Male**		
Date Of Birth	: **22-Apr-1977**		
Patient's Tel No	: **0582760221**		

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 : Presenting for wound dressing of site of peracentesis leak. Said to be seeing specialist at Rashid hospital. Diagnosis and condition being managed uncertain but was instructed to change dressing every 3 days. His next visit is 10th of July (5days from now). **Duration:**

Vitals:

Clinical Findings:

Diagnosis: K76.9 - Liver disease, unspecified, **Date of Onset** : 05/24/2024

Requested Investigations: 10004, DRESSING-SMALL,9, Consultation GP,51.01, Non-surgical cleansing with surgical dressing 16 sq inches / 100 sq centimeters or less **Estimated Cost** :

Prescriptions: **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.

Dr's Name : Enomen Goodluck **Stamp :**

Dr. Enomen Goodluck Ekata
General Practitioner
DHA No: 28040827-001
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

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

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.

Patient 's signature{Parent if minor} : **Date :** 05-Jul-2024