

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name

: ABDUL GHAFAR MUNIR AHMAD

Card No

: I040-029-120695866-01

Policy Holder

: ABDUL GHAFAR MUNIR AHMAD

Payer Name

: UNION INSURANCE COMPANY

TPA

: E CARE - Blue Network

Validity

: 30-03-2024 To 29-03-2025

Gender

: Male

Date Of Birth

: 22-Apr-1977

Patient's Tel No

: 0582760221

Service Date

: 05-Jul-2024

Health Provider

: CITICARE MEDICAL CENTER LLC

Doctor's Name

: Enomen Goodluck

Co-Insurance

:

Remarks

:

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).

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:

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

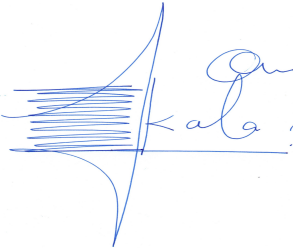
General Practitioner

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 : Jul-2024