Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: NAW NOBLE**
Card No	**: I040-029-120585625-01**
Policy Holder	**: NAW NOBLE**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 02-01-2024** To **01-01-2025**
Gender	**: Female**
Date Of Birth	**: 22-Oct-1992**
Patient's Tel No	**: 0555635483**

Service Date :**06-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: PAIN IN RIGHT ARM 5 DAYS PAIN MODERATE **Duration :**

Vitals: Temp : 37 Bp :120 Pulse :72 Resp :18

Clinical Findings:

Diagnosis: M79.603 - Pain in arm, unspecified, **Date of Onset** : 06/03/2024

Requested Investigations: 0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,9.01, Follow Up Consultation GP,96372, THER/PROPH/DIAG INJ SC/IM **Estimated Cost :**

Prescriptions: 1689-508201-0651 - (EUCALYPTUS OIL : 2 G/100G) (TURPENTINE OIL : 3 G/100G) (MENTHOL : 5 G/100G) (WINTERGREEN OIL : 15 G/100G) OINTMENT,4417-711202-0391 - (IBUPROFEN (AS L-ARGININE SALT) : 400 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 :** 06-Jul-2024

Signature : **Date** : 06-Jul-2024