

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
Health : CITICARE MEDICAL CENTER LLC
Provider :
Doctor's Name : Enomen Goodluck

Network : Green
Direct Access SP - YES

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 :

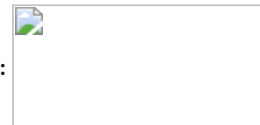
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

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}



06-
Date : Jul-
2024

Signature :

Date : 06-Jul-2024