

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name

MINUSHKA NISAL
PRABHASHWARA
SUBHAWICKRAMA
NANTHILAKAGE . RAVEENDRA

Card No

: I040-029-120424465-01

Policy Holder

MINUSHKA NISAL
PRABHASHWARA
SUBHAWICKRAMA
NANTHILAKAGE . RAVEENDRA

Payer Name

: UNION INSURANCE COMPANY

TPA

: E CARE - Blue Network

Validity

: 05-02-2024 To 01-01-2025

Gender

: Male

Date Of Birth

: 26-Jun-1996

Patient's Tel No

: 0521767326

Service Date

:18-Jul-2024

Health Provider

:CITICARE MEDICAL CENTER LLC

Doctor's Name

:Enomen Goodluck

Co-Insurance

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

Network

: Green

Direct Access SP - YES

Remarks

:

☐ Acute

☐ Pre-existing and chronic

☐ Maternity

Chief Complaints

: PC: Convulsion characterized by upward rolling of the eyes and jerking of the lower limbs. Duration: said to have lasted about 3minutes and aborted spontaneously before he was rushed to the clinic. This is not the first episode in his life, as he had a similar episode some months ago. Last meal was about 20mins prior to presentation. He does not smoke nor take alcohol, nor use any recreational drug. There is no history of head trauma. Plan: Refer to neurologist.

Vitals

:Temp : 36.8 Bp :117 Pulse :76 Resp :18

Clinical Findings:

Diagnosis

: R56.9 - Unspecified convulsions,G40.909 - Epilepsy, unsp, not intractable, without status epilepticus, Date of Onset:19/36/2024

Requested Investigations

: 9, Consultation GP,82947-1, GRBS,0102-111908-1001, SODIUM CHLORIDE B.P.,96365, THER/PROPH/DIAG IV INF INIT

Estimated Cost

:

Prescriptions:

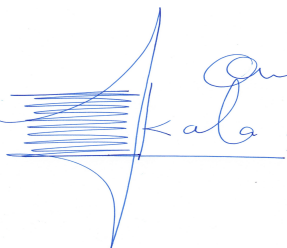
MEDICAL PRACTITIONER DECLARATION :

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

Signature



Stamp

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

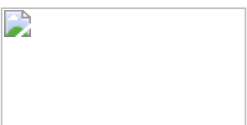
Date

: 19-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

: 19-Jul-2024