Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **MINUSHKA NISAL PRABHASHWARA SUBHAWICKRAMA NANTHILAKAGE . RAVEENDRA**	**Service Date**	**:18-Jul-2024**
Card No	: **I040-029-120424465-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**
Policy Holder	: **MINUSHKA NISAL PRABHASHWARA SUBHAWICKRAMA NANTHILAKAGE . RAVEENDRA**	**Doctor's Name**	**:Enomen Goodluck**
Payer Name	: **UNION INSURANCE COMPANY**	**Remarks**	:
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**		

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

☐ **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. **Duration:**

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: **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** : 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