Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **WALEED MEDANI . SHIEKH ABDURAHMAN**	**Service Date:**	**21-Jul-2024**
Card No	: **I040-029-120879915-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**
Policy Holder	: **WALEED MEDANI . SHIEKH ABDURAHMAN**	**Doctor's Name**	**:Enomen Goodluck**
Payer Name	: **UNION INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **02-01-2024** To **01-01-2025**		
Gender	: **Male**		
Date Of Birth	: **03-Mar-1981**		
Patient's Tel No	: **0586985012**		

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 : PC: Pain in throat since the past 3 days. Also has headache but there is no fever as he has been on paracetamol He is not a known hypertensive and not diabetic. Takes tobacco (vaping) but does not ingest alcohol. Works as IT specialist. ENT: mild hyperemia and hypertrophy. Chest is clinically clear. **Duration:**

Vitals: Temp : 35.8 Bp :108 Pulse :79 Resp :18

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,J03.90 - Acute tonsillitis, unspecified, **Date of Onset** :21/35/2024

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,9, Consultation GP **Estimated Cost** :

Prescriptions: 2027-560101-0392 - (IBUPROFEN : 150 MG) (PARACETAMOL : 500 MG) FILM COATED TABLETS,0005-119805-1172 - (PREDNISOLONE : 5 MG) TABLETS,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,0252-185801-0391 - (DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 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 : 21-Jul-2024

Signature :

Date : 21-Jul-2024