Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: SNEHA SURESH NAIR**
Card No	**: I040-029-120655348-01**
Policy Holder	**: SNEHA SURESH NAIR**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 02-01-2024** To **01-01-2025**
Gender	**: Female**
Date Of Birth	**: 22-Mar-2002**
Patient's Tel No	**: 055980055**

Service Date **:25-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: LOWER BACK ACHE 1 DAY **Duration** :

Vitals: Temp : 37 Bp :90 Pulse :78 Resp :28

Clinical Findings:

Diagnosis: M54.5 - Low back pain, **Date of Onset** : 25/38/2024

Requested Investigations: 9, Consultation GP **Estimated Cost** :

Prescriptions: 4417-711202-0391 - (IBUPROFEN (AS L-ARGININE SALT) : 400 MG) FILM COATED TABLETS,2093-596002-0431 - (DICLOFENAC DIETHYLAMINE : 23.2 MG / G) GEL, **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** : 25-Jul-2024

Signature : **Date** : 25-Jul-2024