Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: ATMARAM VITTAM GOVERDHAN VITTAM . RAVEENDRA**
Card No	**: I040-029-120443069-01**
Policy Holder	**: ATMARAM VITTAM GOVERDHAN VITTAM . RAVEENDRA**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 02-01-2024** To **01-01-2025**
Gender	**: Male**
Date Of Birth	**: 25-Jun-1991**
Patient's Tel No	**: 0507449890**

Service Date **:01-Aug-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: Corn and exfoliation of the palmar surfaces of the fingers Works as a house keeper in hotel. Also pain on the right knee from a fall yesterday. **Duration:**

Vitals: Temp : 36.4 Bp :123 Pulse :53 Resp :18

Clinical Findings:

Diagnosis: M25.561 - Pain in right knee,G89.11 - Acute pain due to trauma, **Date of Onset** :02/02/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Estimated Cost :

Prescriptions: 0027-149904-0341 - (DICLOFENAC SODIUM : 50 MG) ENTERIC COATED TABLETS,

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 :** 02-Aug-2024

Signature : **Date** : 02-Aug-2024