

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name

: MOHAMMED SHAHAB UDDIN ABDUL MABUD

Card No

: I040-029-119600415-01

Policy Holder

: MOHAMMED SHAHAB UDDIN ABDUL MABUD

Payer Name

: UNION INSURANCE COMPANY

TPA

: E CARE - Blue Network

Validity

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

Gender

: Male

Date Of Birth

: 08-Mar-1985

Patient's Tel No

: 0581676397

Service Date

: 02-Aug-2024

Health Provider

: CITICARE MEDICAL CENTER LLC

Doctor's Name

: Enomen Goodluck

Co-Insurance

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: SVERE ALLERFY

Duration :

Vitals:

Clinical Findings:

Diagnosis: L23.89 - Allergic contact dermatitis due to other agents,

Date of Onset : 02/32/2024

Requested Investigations: 0005-111805-1021, CHLOROHISTOL 10MG-(CHLORPHENIRAMINE MALEATE : 10 MG/ML) SOLUTION FOR INJECTION,96365, THER/PROPH/DIAG IV INF INIT,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP

Estimated : Cost

Prescriptions: 0195-123701-0391 - CETIRIZINE HCL,0027-109206-0151 - (TERBINAFINE (AS HCL) : 1%) CREAM,

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

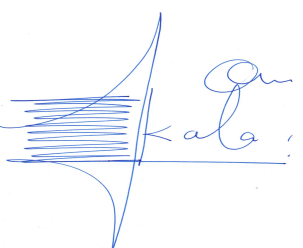
General Practitioner

DHA No: 28040827-001

CITICARE MEDICAL CENTER LLC

DUBAI - U.A.E.

Signature :



Date

: 02-Aug-2024

Patient 's signature{Parent : if minor}



Date

: Aug-2024