Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **MOHAMMED SHAHAB UDDIN ABDUL MABUD**	**Service Date**	**:02-Aug-2024**
Card No	: **I040-029-119600415-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**
Policy Holder	: **MOHAMMED SHAHAB UDDIN ABDUL MABUD**	**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	: **08-Mar-1985**		
Patient's Tel No	: **0581676397**		

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.

Patient 's signature{Parent if minor} : **Date** : 02-Aug-2024

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