## Administrative MEDICAL CLAIM FORM Claim Ref:

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|---|---|---|---|
| **Patient Name** | : **HASEEB LODHI GHAZANFAR MEHMOOD** | **Service Date:** | **05-Aug-2024** |
| **Card No** | : **I040-029-117681852-01** | **Health Provider** | **:CITICARE MEDICAL CENTER LLC** |
| **Policy Holder** | : **HASEEB LODHI GHAZANFAR MEHMOOD** | **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** | : **06-Dec-1995** | | |
| **Patient's Tel No** | : **0521005291** | | |

**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: ACUTE GASTROENTERITIS **Duration :**

**Vitals:**Temp : 36.6 Bp :100 Pulse :80 Resp :18

**Clinical Findings:**

**Diagnosis:** A09 - Infectious gastroenteritis and colitis, unspecified,R10.13 - Epigastric pain,R10.0 - Acute abdomen, **Date of Onset:**05/06/2024

**Requested Investigations:** 9.01, Follow Up Consultation GP,0005-107704-0802, TRIAXONE I.V.-(CEFTRIAXONE : 1 G) POWDER FOR INJECTION,0005-136504-1021, SCOPINAL-(HYOSCINE : 20 MG/ML) SOLUTION FOR INJECTION,0005-174202-0781, RISEK 40MG-(OMEPRAZOLE : 40 MG) POWDER FOR INFUSION,96365, THER/PROPH/DIAG IV INF INIT,96374, THER/PROPH/DIAG INJ IV PUSH **Estimated Cost :**

**Prescriptions:** 0207-533801-1451 - (ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) CAPSULES (HARD GELATIN),0005-136501-0393 - (HYOSCINE : 10 MG) FILM COATED TABLETS,0152-116604-0391 - (METRONIDAZOLE : 500 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 :** 05-Aug-2024

**Signature :**

**Date** : 05-Aug-2024