Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: MOHAMED ENAYATULLAH KHAN**
Card No	**: I040-029-117305023-01**
Policy Holder	**: MOHAMED ENAYATULLAH KHAN**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 02-01-2024** To **01-01-2025**
Gender	**: Male**
Date Of Birth	**: 29-Nov-1978**
Patient's Tel No	**: 0563014230**

Service Date :**07-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 : Highly pruritic lesions on the groin area. Exam: hyperpigmented scaly lesions **Duration:** in the groin bilaterally.

Vitals: Temp : 37.5 Bp :124 Pulse :75 Resp :18

Clinical Findings:

Diagnosis: L29.9 - Pruritus, unspecified, **Date of Onset** : 07/09/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0207-214402-0151 - (BETAMETHASONE : N/A) (CLOTRIMAZOLE : N/A) CREAM,0031-109204-1172 - (TERBINAFINE (AS HCL) : 250 MG) 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

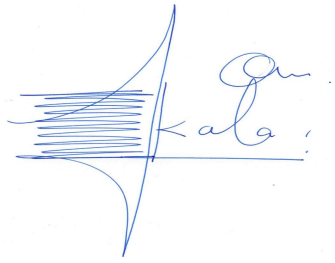
Stamp :

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 : 07-Aug-2024

Signature :



Date : 07-Aug-2024