Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **DEEPAK KUMAR . RAVEENDRA**	**Service Date**	:**15-Aug-2024**
Card No	: **I040-029-120358979-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC**
Policy Holder	: **DEEPAK KUMAR . RAVEENDRA**	**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-Jan-1986**		
Patient's Tel No	: **0547325221**		

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: Pain on the right elbow joint following a fall Duration: 5hours. Said to have slipped and fell in the bathroom thus resulting in the injury Exam: abrasion to the right elbow joint posteriorly. Able to flex the right upper limb actively but with associated pain. X-ray is advised (PATIENT DECLINED, despite counsel to the contrary)_. **Duration:**

Vitals: Temp : 37 Bp :124 Pulse :73 Resp :20

Clinical Findings:

Diagnosis: M25.521 - Pain in right elbow,G89.11 - Acute pain due to trauma, **Date of Onset** :15/05/2024

Requested Investigations: 0005-149902-1021, CLOFEN ,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP **Estimated Cost** :

Prescriptions: 0046-159501-0341 - (SERRATIOPEPTIDASE : 5 MG) ENTERIC COATED TABLETS,0027-149903-0391 - (DICLOFENAC SODIUM : 100 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.

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 : 15-Aug-2024

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.

Patient 's signature{Parent if minor} :

Date : 15-Aug-2024