Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: CHIGOZIE FRANCIS ONWUASOANYA**
Card No	**: I040-029-117072633-01**
Policy Holder	**: CHIGOZIE FRANCIS ONWUASOANYA**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 02-01-2024** To **01-01-2025**
Gender	**: Male**
Date Of Birth	**: 04-Sep-1990**
Patient's Tel No	**: 971555429234**

Service Date :17-Aug-2024 **Network** : Green

Health Provider **:CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**

Doctor's Name **:AHSAN HUSSAIN**

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 : PC: ALLERGIC DERMATITIS **Duration :**

Vitals: Temp : 36.7 Bp :106 Pulse :74 Resp :18

Clinical Findings:

Diagnosis: L23.89 - Allergic contact dermatitis due to other agents, **Date of Onset :**17/26/2024

Requested Investigations: 0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,0005-111805-1021, CHLOROHISTOL 10MG-(CHLORPHENIRAMINE MALEATE : 10 MG/ML) SOLUTION FOR INJECTION,96372, THER/PROPH/DIAG INJ SC/IM,86005, ALLERGEN SPECIFIC IGE QUAL MULTIALLERGEN SCREEN,9, Consultation GP **Estimated Cost :**

Estimated Cost :

Prescriptions: 0195-123701-0391 - CETIRIZINE HCL,

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 :

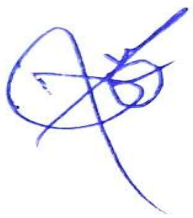
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : AHSAN HUSSAIN **Stamp :**

Patient 's signature{Parent if minor} :

Date : 17-Aug-2024

Signature :



Date : 17-Aug-2024