Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: GANGA KERUNG**
Card No	**: I040-029-113718932-01**
Policy Holder	**: GANGA KERUNG**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 02-01-2024** To **01-01-2025**
Gender	**: Male**
Date Of Birth	**: 08-Oct-1981**
Patient's Tel No	**: 0503621186**

Service Date :**19-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 : PC: Fever, pain in throat and headache, Duration: 3days. BP also noted to be increasing consistently. Had cholecystectomy 3 years ago. **Duration:**

Vitals: Temp : 36.5 Bp :140 Pulse :70 Resp :20

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,R50.9 - Fever, unspecified,R07.0 - Pain in throat,R03.0 - Elevated blood-pressure reading, w/o diagnosis of htn, **Date of Onset** :19/16/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 1516-107902-1171 - (IBUPROFEN : 400 MG) TABLETS,1343-383501-0582 - (BENZOCAINE : 6 MG) (MENTHOL : 10 MG) LOZENGES,1144-253101-1162 - (HEDERA HELIX (IVY) : 7MG/ML) SYRUP,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,0788-106705-1171 - (CHLORPHENIRAMINE MALEATE : 2 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) TABLETS, **Estimated Cost** :

MEDICAL PRACTITIONER DECLARATION :

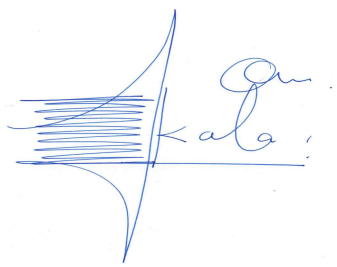
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

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 : 19-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 : 19-Aug-2024