Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **PRASHANTH KUMAR ETIKYALA RAJAIAH ETIKYALA**	**Service Date**	**:22-Aug-2024**	**Network**	**:** Green
Card No	: **I005-029-117211820-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**	**Direct Access SP - YES**	
Policy Holder	: **PRASHANTH KUMAR ETIKYALA RAJAIAH ETIKYALA**	**Doctor's Name**	**:Enomen Goodluck**		
Payer Name	: **DUBAI INSURANCE COMPANY**	**Co-Insurance**	:		
TPA	: **E CARE - Blue Network**				
Validity	: **23-11-2023** To **22-11-2024**	**Remarks**	:		
Gender	: **Male**				
Date Of Birth	: **21-Aug-1997**				
Patient's Tel No	: **0569746234**				

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 in throat, headache, runny nose, nasal congestion and itching throat. Duration: 5days. There is associated fever for which he has been taking panadol self prescribed. Also has change in voice. Not hypertensive not diabetic, and has no previous medical condition in the past. **Duration:**

Vitals: Temp : 37.3 Bp :131 Pulse :87 Resp :22

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,J30.9 - Allergic rhinitis, unspecified,R51.9 - Headache, unspecified, **Date of Onset** :22/58/2024

Requested Investigations: 0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,0005-149902-1021, CLOFEN ,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP **Estimated Cost** :

Prescriptions: 0097-127405-0392 - (AZITHROMYCIN : 500 MG) FILM COATED TABLETS,2027-560101-0392 - (IBUPROFEN : 150 MG) (PARACETAMOL : 500 MG) FILM COATED TABLETS,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,0252-185801-0391 - (DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS,0005-116801-1161 - (SODIUM CITRATE : 57 MG/5ML) (AMMONIUM CHLORIDE : 131.5 MG/5 ML) (MENTHOL : 1.1 MG/5 ML) (DIPHENHYDRAMINE : 13.5 MG/5ML) SYRUP, **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 :** 22-Aug-2024

Signature : **Date** : 22-Aug-2024