Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **HASRAT MUSTAFA MULLAJI MUSTAFA UMER MULLAJI**	**Service Date**	**:24-Aug-2024**	**Network**	**:** Green
Card No	: **I040-029-119070553-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**	**Direct Access SP - YES**	
Policy Holder	: **HASRAT MUSTAFA MULLAJI MUSTAFA UMER MULLAJI**	**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	: **16-Aug-1993**				
Patient's Tel No	: **971563093585**				

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 : Fever, diarrhea and weakness since last night. Had 6 episodes of loose motion last night only. Had dinner in a nearby restaurant last night before bed time. **Duration:**

Vitals: Temp : 37.1 Bp :92 Pulse :82 Resp :18

Clinical Findings:

Diagnosis: K52.9 - Noninfective gastroenteritis and colitis, unspecified,R19.7 - Diarrhea, unspecified,R53.1 - Weakness,I95.9 - Hypotension, unspecified,E86.0 - Dehydration, **Date of Onset** :24/57/2024

Requested Investigations: 96360, HYDRATION IV INFUSION INIT,0102-152902-1001, LACTATED RINGERS INJECTION USP,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,87045, CUL BACT STOOL AEROBIC ISOL SALMONELLA&SHIGELLA,9, Consultation GP **Estimated Cost** :

Prescriptions: 1350-502201-1113 - (SPORE OF BACILLUS CLAUSI : 2 BILLION/5ML) SUSPENSION,5792-876903-0831 - (GLUCOSE MONOHYDRATE : 2.97 G) (TRISODIUM CITRATE DIHYDRATE : 0.58 G) (POTASSIUM CHLORIDE : 0.3 G) (SODIUM CHLORIDE : 0.52 G) POWDER FOR SOLUTION,0415-200001-1452 - (LOPERAMIDE : 2 MG) CAPSULES (HARD GELATIN), **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 :** 24-Aug-2024

Signature : **Date** : 24-Aug-2024