

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : RAMESH CHANDRA PATIDAR

Card No : I040-029-113722477-01

Policy Holder : RAMESH CHANDRA PATIDAR

Payer Name : UNION INSURANCE COMPANY

TPA : E CARE - Blue Network

Validity : 02-01-2024 To 01-01-2025

Gender : Male

Date Of Birth : 15-Jul-1978

Patient's Tel No : 0563834759

Service Date :01-Sep-2024

Health Provider :CITICARE MEDICAL CENTER LLC

Doctor's Name :Enomen Goodluck

Co-Insurance :

Remarks :

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: Cough, pain in throat, fever, and nasal congestion Duration: 4days. Duration:

Smokes and takes alcohol.

Vitals:Temp : 36.8 Bp :139 Pulse :67 Resp :18

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,J20.9 - Acute bronchitis, unspecified,R50.9 - Fever, Date of Onset :01/50/2024 unspecified,J30.9 - Allergic rhinitis, unspecified,

Estimated Cost : Requested Investigations: 9, Consultation GP

Prescriptions: 0097-127405-0392 - (AZITHROMYCIN : 500 MG) FILM COATED TABLETS,0005-119803-1171 - (PREDNISOLONE : 20 MG) 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,0696-148701-1172 - (LORATADINE : 10 MG) TABLETS,0252-185801-0391 - (DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS,

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 :

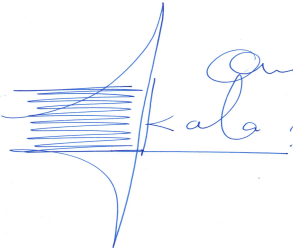
Dr. Enomen Goodluck Ekata

General Practitioner

DHA No: 28040827-001

CITICARE MEDICAL CENTER LLC

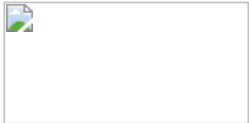
DUBAI - U.A.E.

Signature :

Date : 01-Sep-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 : Sep-2024