Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **JAHANGIR ALAM TAZUL ISLAM**	**Service Date**	:**01-Sep-2024**
Card No	: **I040-029-118710008-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC**
Policy Holder	: **JAHANGIR ALAM TAZUL ISLAM**	**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	: **20-Apr-1978**		
Patient's Tel No	: **0568204143**		

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 : Pain and swelling on the dorsum of the left foot. Duration: 1month. No history of trauma. ALSO FREQUENCY OF URINATION. Not diabetic and not hypertensive. UA requested.

Duration:

Vitals: Temp : 35.7 Bp :110 Pulse :83 Resp :18

Clinical Findings:

Diagnosis: M10.9 - Gout, unspecified,R22.43 - Localized swelling, mass and lump, lower limb, bilateral,R52 - Pain, unspecified,E83.52 - Hypercalcemia,N39.0 - Urinary tract infection, site not specified,

Date of Onset :01/04/2024

Requested Investigations: 82310, CALCIUM TOTAL,82330, CALCIUM IONIZED,84550, URIC ACID BLOOD,9, Consultation GP

Estimated Cost :

Prescriptions: 0135-223401-1171 - (NAPROXEN : 500 MG) TABLETS,0005-119803-1171 - (PREDNISOLONE : 20 MG) TABLETS,0046-159501-0341 - (SERRATIOPEPTIDASE : 5 MG) ENTERIC COATED TABLETS,1161-274301-0392 - (LEVOFLOXACIN (AS HEMIHYDRATE) : 500 MG) FILM COATED 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 : 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 : 01-Sep-2024