Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: GANGA KERUNG	**Service Date**	:06-Sep-2024
Card No	: I040-029-113718932-01	**Health Provider**	:CITICARE MEDICAL CENTER LLC
Policy Holder	: GANGA KERUNG	**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	: 08-Oct-1981		
Patient's Tel No	: 0503621186		

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 : **Duration :**

Vitals:

Clinical Findings:

Diagnosis: J20.9 - Acute bronchitis, unspecified,R50.9 - Fever, unspecified,M79.10 - Myalgia, unspecified site,N39.0 - Urinary tract infection, site not specified, **Date of Onset** :06/15/2024

Requested Investigations: 9.01, Follow Up Consultation GP,0195-107704-0802, CEFTRIAXONE-TABUK IM,96365, THER/PROPH/DIAG IV INF INIT **Estimated Cost** :

Estimated Cost :

Prescriptions:

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** : 06-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 :** 06-Sep-2024