

Administrative

Patient Name : GANGA KERUNG

Card No : I040-029-113718932-01

Policy Holder : GANGA KERUNG

Payer Name : UNION INSURANCE COMPANY

TPA : E CARE - Blue Network

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

Gender : Male

Date Of Birth : 08-Oct-1981

Patient's Tel No : 0503621186

MEDICAL CLAIM FORM

Service Date :06-Sep-2024

Health Provider :CITICARE MEDICAL CENTER LLC

Doctor's Name :Enomen Goodluck

Co-Insurance :

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

Remarks :

Claim Ref:

Network : Green

Direct Access SP - YES

☐ Acute

☐ Pre-existing and chronic

☐ Maternity

Chief Complaints : Duration :

Vitals:

Clinical Findings:

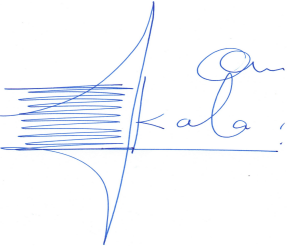
Diagnosis: J20.9 - Acute bronchitis, unspecified,R50.9 - Fever, unspecified,M79.10 - Myalgia, unspecified site,N39.0 - Urinary tract infection, site not specified, Date of Onset :06/15/2024

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

Prescriptions: 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

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.

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 : Sep-2024