

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : THI HA AUNG

Card No : I040-029-120585630-01

Policy Holder : THI HA AUNG

Payer Name : UNION INSURANCE COMPANY

TPA : E CARE - Blue Network

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

Gender : Male

Date Of Birth : 16-Feb-2001

Patient's Tel No : 0559542312

Service Date :08-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 :

Network : Green

Direct Access SP - YES

☐ Acute

☐ Pre-existing and chronic

☐ Maternity

Chief Complaints : Headache, fever, back pain, generalized body pains and low back pains

Duration: 2days. Also has cough and pain in throat.

Vitals:Temp : 38.9 Bp :131 Pulse :117 Resp :18

Clinical Findings:

Diagnosis: J22 - Unspecified acute lower respiratory infection,R50.9 - Fever, unspecified,M79.10 - Myalgia, unspecified site,K29.00 - Acute gastritis without bleeding,

Date of Onset :08/41/2024

Requested Investigations: 96365, THER/PROPH/DIAG IV INF INIT,0195-107704-0801, CEFTRIAXONE-TABUK IV,0005-149902-1021, CLOFEN ,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,2190-106618-1001, PARAFUSIV,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,0005-174202-0781, RISEK 40MG,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP

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

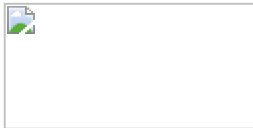
DUBAI - U.A.E.

Signature : 

Date : 08-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

https://irhamc.visionsoftwares.ae/mr_ecare_claim_print.aspx?appld=52472&patld=53697

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