

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name

: MUKUL ANAND SHEKHAR SINGH

Card No

: I040-029-120035873-01

Policy Holder

: MUKUL ANAND SHEKHAR SINGH

Payer Name

: UNION INSURANCE COMPANY

TPA

: E CARE - Blue Network

Validity

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

Gender

: Male

Date Of Birth

: 07-Aug-1997

Patient's Tel No

: 0565912983

Service Date

:12-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: High grade fever since this this morning Has associated cough and generalized body pains. Also has cough. and sneezing and pain in throat.

Duration:

Vitals

:Temp : 38.8 Bp :128 Pulse :121 Resp :18

Clinical Findings:

Diagnosis

: J06.9 - Acute upper respiratory infection, unspecified,R50.9 - Fever, unspecified,M79.10 - Myalgia, unspecified site,R51.9 - Headache, unspecified,R05 - Cough,

Date of Onset

:12/39/2024

Requested Investigations

: 96372, THER/PROPH/DIAG INJ SC/IM,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,96365, THER/PROPH/DIAG IV INF INIT,96374, THER/PROPH/DIAG INJ IV PUSH,9, Consultation GP

Estimated Cost

:

Prescriptions

: 1643-383501-0582 - (BENZOCAINE : 6 MG) (MENTHOL : 10 MG) LOZENGES,0027-265802-1161 - (BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V) SYRUP,1516-107902-1171 - (IBUPROFEN : 400 MG) TABLETS,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,5363-863401-1171 - (PARACETAMOL : 400 MG) (PSEUDOEPHEDRINE HCL : 30 MG) (CAFFEINE : 32 MG) (CHLORPHENIRAMINE MALEATE : 3 MG) 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.

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.

Dr's Name

: Enomen Goodluck

Stamp

Signature

Date

: 12-Sep-2024

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