Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: SEKH ESTYAK ALI SEKH AKTHAR ALI**
Card No	**: I040-029-118843245-01**
Policy Holder	**: SEKH ESTYAK ALI SEKH AKTHAR ALI**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 02-01-2024** To **01-01-2025**
Gender	**: Male**
Date Of Birth	**: 20-Dec-1992**
Patient's Tel No	**: 0528452339**

Service Date :**12-Sep-2024** **Network** : Green

Health Provider :**CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**

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 :

☐ **Acute** ☐ **Pre-existing and chronic** ☐ **Maternity**

Chief Complaints : Generalized body itching. Duration: 2months. A history of allergic dermatitis. **Duration:**

Vitals: Temp : 37 Bp :119 Pulse :78 Resp :18

Clinical Findings:

Diagnosis: L20.9 - Atopic dermatitis, unspecified,L29.9 - Pruritus, unspecified,B35.4 - Tinea corporis,K21.9 - Gastro-esophageal reflux disease without esophagitis,R10.13 - Epigastric pain,R11.0 - Nausea, **Date of Onset** :12/44/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0005-119805-1172 - (PREDNISOLONE : 5 MG) TABLETS,0137-242801-0342 - (PANTOPRAZOLE (AS SODIUM) : 20 MG) ENTERIC COATED TABLETS,0031-109204-1172 - (TERBINAFINE (AS HCL) : 250 MG) TABLETS,1111-183201-0391 - (FEXOFENADINE HCL : 120 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.

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

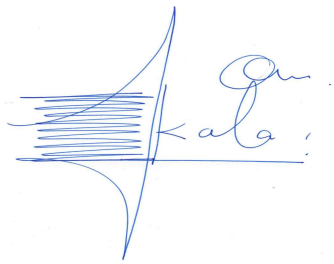
Stamp :

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 : 12-Sep-2024

Signature :



Date : 12-Sep-2024