Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: AGGREY ONYANGO**	**Service Date**	**:12-Sep-2024**
Card No	**: I040-029-116125957-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**
Policy Holder	**: AGGREY ONYANGO**	**Doctor's Name**	**:Enomen Goodluck**
Payer Name	**: UNION INSURANCE COMPANY**	**Co-Insurance**	**:**
TPA	**: E CARE - Green Network**	**Remarks**	**:**
Validity	**: 01-01-2024 To 05-06-2025**		
Gender	**: Male**		
Date Of Birth	**: 12-Nov-1983**		
Patient's Tel No	**: 0543892858**		

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: Temp : 35.9 Bp :159 Pulse :59 Resp :18

Clinical Findings:

Diagnosis: **Date of Onset** **:** 13/32/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Estimated Cost :

Prescriptions:

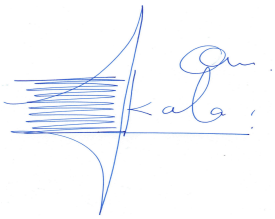
MEDICAL PRACTITIONER DECLARATION :

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 : 13-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 : 13-Sep-2024