Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: LAKAI MITRA JATINDRA MITRA MITRA**
Card No	**: I040-029-113719086-01**
Policy Holder	**: LAKAI MITRA JATINDRA MITRA MITRA**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 02-01-2024** To **01-01-2025**
Gender	**: Male**
Date Of Birth	**: 05-Mar-1982**
Patient's Tel No	**: 508842935**

Service Date :20-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 : PC: Feeling of abdominal fullness, bloating DUration: 3days **Duration :**

Vitals: Temp : 36.6 Bp :106 Pulse :74 Resp :18

Clinical Findings:

Diagnosis: K29.00 - Acute gastritis without bleeding,R14.0 - Abdominal distension (gaseous),R19.7 - Diarrhea, unspecified,E11.65 - Type 2 diabetes mellitus with hyperglycemia,K58.0 - Irritable bowel syndrome with diarrhea, **Date of Onset** :20/39/2024

Estimated Cost :

Requested Investigations: 82947-1, GRBS,9, Consultation GP

Prescriptions: 0265-150407-1171 - (METOCLOPRAMIDE : 10 MG) TABLETS,0005-141604-0081 - (ALUMINIUM HYDROXIDE : 200 MG) (MAGNESIUM HYDROXIDE : 200 MG) (SIMETHICONE : 25 MG) CHEWABLE TABLETS,0137-174201-1452 - (OMEPRAZOLE : 20 MG) CAPSULES (HARD GELATIN), **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 :** 20-Sep-2024

Signature : **Date** : 20-Sep-2024