Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **GABE EMMANUELLE GETIGAN MORCILLA**	**Service Date**	:**28-Sep-2024** **Network** : Green
Card No	: **I011-029-120515766-03**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **GABE EMMANUELLE GETIGAN MORCILLA**	**Doctor's Name**	:**Enomen Goodluck**
Payer Name	: **AL SAGR NATIONAL INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **01-07-2024** To **30-06-2025**		
Gender	: **Male**		
Date Of Birth	: **22-Sep-2002**		
Patient's Tel No	: **0589578846**		

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: Diarrhea and upper abdominal pain Duration: 27/09/2024 Has had 3 episodes this evening. Also has upper abdominal pain and weakness. There is no fever and no blood in stool and no mucus in stool. **Duration:**

Vitals: Temp : 37.1 Bp :110 Pulse :82 Resp :18

Clinical Findings:

Diagnosis: K52.9 - Noninfective gastroenteritis and colitis, unspecified,K29.00 - Acute gastritis without bleeding,R19.7 - Diarrhea, unspecified,R53.1 - Weakness,E86.0 - Dehydration, **Date of Onset** :28/16/2024

Requested Investigations: 96360, HYDRATION IV INFUSION INIT,80051, ELECTROLYTE PANEL,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,0102-152902-1001, LACTATED RINGERS INJECTION USP,0005-242802-0781, PANTONIX 40MG I.V.,0005-136504-1021, SCOPINAL,96374, THER/PROPH/DIAG INJ IV PUSH,9, Consultation GP **Estimated Cost** :

Prescriptions: 0005-106601-0052 - (PARACETAMOL : 500 MG) CAPLETS,0042-136501-1173 - (HYOSCINE : 10 MG) TABLETS,0137-242801-0342 - (PANTOPRAZOLE (AS SODIUM) : 20 MG) ENTERIC COATED TABLETS,0415-200001-1452 - (LOPERAMIDE : 2 MG) CAPSULES (HARD GELATIN),0097-230603-2091 - (ORAL REHYDRATION SALTS (O.R.S.) : N/A) ORAL POWDER, **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 :** 28-Sep-2024

Signature : **Date** : 28-Sep-2024