Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **PUPUT ADI CANDRA**	**Service Date**	:**29-Sep-2024**
Card No	: **I040-029-117763282-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC**
Policy Holder	: **PUPUT ADI CANDRA**	**Doctor's Name**	:**Enomen Goodluck**
Payer Name	: **UNION INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **02-01-2024** To **01-01-2025**		
Gender	: **Female**		
Date Of Birth	: **03-Jan-2003**		
Patient's Tel No	: **0562363186**		

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 : Swelling and pain on the lower abdomen. duration: 3days (26/09/2024). ExaM: Hyperemic, inflammed mass, measures 7cm in it's widest axis (as per picture). physical examination declined.

Duration:

Vitals: Temp : 37.1 Bp :100 Pulse :76 Resp :18

Clinical Findings:

Diagnosis: L02.221 - Furuncle of abdominal wall,L03.311 - Cellulitis of abdominal wall,R50.9 - Fever, unspecified, **Date of Onset:**30/55/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 1516-107902-1171 - (IBUPROFEN : 400 MG) TABLETS,0097-116207-0392 - (AMOXICILLIN : 500 MG) (CLAVULANIC ACID : 125 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 : 30-Sep-2024

Signature :

Date : 30-Sep-2024