Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **HASEEB LODHI GHAZANFAR MEHMOOD**	**Service Date**	:**03-Oct-2024**
Card No	: **I040-029-117681852-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC**
Policy Holder	: **HASEEB LODHI GHAZANFAR MEHMOOD**	**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	: **Male**		
Date Of Birth	: **06-Dec-1995**		
Patient's Tel No	: **0521005291**		

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 : PC: Sorethroat, body painsm nasal congestion, runny nose and sneezing. Duration: 3days. Has no other complain **Duration:**

Vitals: Temp : 36.3 Bp :94 Pulse :78 Resp :18

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,R50.9 - Fever, unspecified,R07.0 - Pain in throat,R09.81 - Nasal congestion,I95.9 - Hypotension, unspecified, **Date of Onset** :03/31/2024

Requested Investigations: 96360, HYDRATION IV INFUSION INIT,0005-149902-1021, CLOFEN ,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP **Estimated Cost** :

Prescriptions: 0097-127405-0392 - (AZITHROMYCIN : 500 MG) FILM COATED TABLETS,0027-265802-1161 - (BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V) SYRUP,0696-148701-1172 - (LORATADINE : 10 MG) TABLETS,1516-107902-1171 - (IBUPROFEN : 400 MG) TABLETS,0005-119803-1171 - (PREDNISOLONE : 20 MG) 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 :** 03-Oct-2024

Signature : **Date** : 03-Oct-2024