Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: CHARLENE RAMSAMY	**Service Date**	:08-Oct-2024	**Network**	: Green
Card No	: I022-029-118918862-01	**Health Provider**	:CITICARE MEDICAL CENTER LLC		**Direct Access SP - YES**
Policy Holder	: CHARLENE RAMSAMY	**Doctor's Name**	:Enomen Goodluck		
Payer Name	: TAKAFUL EMARAT				
TPA	: E CARE - Blue Network				
Validity	: 16-10-2023 To 15-10-2024				
Gender	: Female				
Date Of Birth	: 30-Jul-1980				
Patient's Tel No	: 0557230485				

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: Nasal congestion, runny nose, fever, pain in throat and fever. Has no cough but has chest pain as well. Currently having marital challenges. **Duration:**

Vitals: Temp : 37.4 Bp :120 Pulse :96 Resp :18

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,J30.9 - Allergic rhinitis, unspecified,R50.9 - Fever, unspecified,M79.10 - Myalgia, unspecified site, **Date of Onset** :08/14/2024

Requested Investigations: 0005-149902-1021, CLOFEN ,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,96372, THER/PROPH/DIAG INJ SC/IM,96360, HYDRATION IV INFUSION INIT,0102-111908-1001, SODIUM CHLORIDE B.P.-(SODIUM CHLORIDE : 0.9% W/V) SOLUTION FOR INFUSION,9, Consultation GP **Estimated Cost :**

Prescriptions: 0027-128802-2021 - (XYLOMETAZOLINE HYDROCHLORIDE : 0.1%) NASAL DROPS,0097-127405-0392 - (AZITHROMYCIN : 500 MG) FILM COATED TABLETS,2027-560101-0392 - (IBUPROFEN : 150 MG) (PARACETAMOL : 500 MG) FILM COATED TABLETS,0005-119803-1171 - (PREDNISOLONE : 20 MG) TABLETS,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,0252-185801-0391 - (DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 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

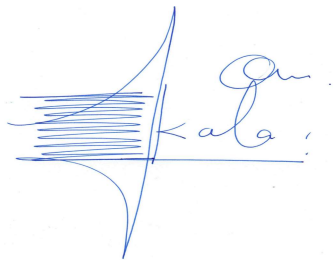
Stamp :

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 : 08-Oct-2024

Signature :



Date : 08-Oct-2024