Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **GANGA KERUNG**	**Service Date**	:**11-Oct-2024**
Card No	: **I040-029-113718932-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC**
Policy Holder	: **GANGA KERUNG**	**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	: **08-Oct-1981**		
Patient's Tel No	: **0503621186**		

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 : **Duration :**

Vitals:

Clinical Findings:

Diagnosis: R17 - Unspecified jaundice,R10.811 - Right upper quadrant abdominal tenderness, **Date of Onset** :11/58/2024

Requested Investigations: 9.01, Follow Up Consultation GP,82247, BILIRUBIN TOTAL,82248, BILIRUBIN DIRECT,80076, HEPATIC FUNCTION PANEL **Estimated Cost** :

Prescriptions: **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.

Dr's Name : Enomen Goodluck

Stamp :

Dr. Enomen Goodluck Ekata
General Practitioner
DHA No: 28040827-001
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

Signature :

Date : 11-Oct-2024

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.

Patient 's signature{Parent if minor} :

Date : 11-Oct-2024