Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **JEET BAHADUR KHATRI**
Card No	: **I040-029-120209240-01**
Policy Holder	: **JEET BAHADUR KHATRI**
Payer Name	: **UNION INSURANCE COMPANY**
TPA	: **E CARE - Blue Network**
Validity	: **02-01-2024** To **01-01-2025**
Gender	: **Male**
Date Of Birth	: **02-Aug-1980**
Patient's Tel No	: **0504753940**

Service Date :**12-Oct-2024** **Network** : Green

Health Provider :**CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**

Doctor's Name :**Enomen Goodluck**

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: Upper abdomninal pain following the ingestion of NSAIDs. Has long standing low back pain for which he took analgesics over the counter. There is no fever There is no nausea and no vomiting BP at presentation: 193/114mmhg. **Duration:**

Vitals: Temp : 36.7 Bp :193 Pulse :84 Resp :18

Clinical Findings:

Diagnosis: K29.00 - Acute gastritis without bleeding,R10.13 - Epigastric pain,I16.0 - Hypertensive urgency, **Date of Onset :**12/24/2024

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86677, ANTIBODY HELICOBACTER PYLORI,96374, THER/PROPH/DIAG INJ IV PUSH,0005-174202-0781, RISEK 40MG,0005-136504-1021, SCOPINAL,96365, THER/PROPH/DIAG IV INF INIT,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,9, Consultation GP **Estimated Cost :**

Prescriptions: 0333-190801-0081 - (ALUMINIUM HYDROXIDE : 300 MG) (SIMETHICONE : 10 MG) (MAGNESIUM HYDROXIDE : 25 MG) (MAGNESIUM TRISILICATE : 50 MG) CHEWABLE TABLETS,0186-143701-0062 - (CELECOXIB : 200 MG) CAPSULES,2104-379202-1451 - (AMLODIPINE (AS BESYLATE) : 10 MG) CAPSULES (HARD GELATIN),0042-136501-1173 - (HYOSCINE : 10 MG) TABLETS,0188-232401-0392 - (ESOMEPRAZOLE : 40 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 : 12-Oct-2024

Signature :

Date : 12-Oct-2024