Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: GANGA KERUNG
Card No	: I040-029-113718932-01
Policy Holder	: GANGA KERUNG
Payer Name	: UNION INSURANCE COMPANY
TPA	: E CARE - Blue Network
Validity	: 02-01-2024 To 01-01-2025
Gender	: Male
Date Of Birth	: 08-Oct-1981
Patient's Tel No	: 0503621186

Service Date :13-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 : **Duration** :

Vitals:

Clinical Findings:

Diagnosis: R17 - Unspecified jaundice,R10.811 - Right upper quadrant abdominal tenderness, **Date of Onset** :13/05/2024

Estimated Cost :

Requested Investigations: 80076, HEPATIC FUNCTION PANEL,9.01, Follow Up Consultation GP

Estimated Cost :

Prescriptions:

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

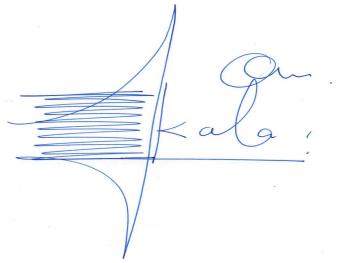
Stamp :

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 : 13-Oct-2024

Signature :



Date : 13-Oct-2024