

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : charlotte samantha
Card No : I035-029-120647414-01
Policy Holder : charlotte samantha
Payer Name : SALAMA – Islamic Arab Insurance Company
TPA : E CARE - Blue Network
Validity : 19-09-2024 To 18-09-2025
Gender : Female
Date Of Birth : 30-Jan-2000
Patient's Tel No : 0506893097

Service Date :29-Oct-2024
Health Provider :CITICARE MEDICAL CENTER LLC
Doctor's Name :Enomen Goodluck
Co-Insurance :

CONSULTATION	LAB/ RADIOLOGY	PHYSIO	PHARMACY	IP	MATEF
10% max	NIL	NIL	NIL LIMIT	NIL	10%

Network : Green
Direct Access S

Remarks :

☐ Acute ☐ Pre-existing and chronic ☐ Maternity

Chief Complaints : PC: Exfoliating lesions on the surface of the 2nd, 3rd and 4th toe of left leg. **Duration:**

Duration: 3months ago. Known asthmatic but haven't had exarcerbation in many. years.

Significant family history of dermatitis. Not hypertensive and not diabetic.

Vitals:Temp : 37 Bp :102 Pulse :87 Resp :18

Clinical Findings:

Diagnosis: L30.9 - Dermatitis, unspecified,J45.20 - Mild intermittent asthma, uncomplicated,E55.9 - Vitamin D deficiency, unspecified, **Date of Onset**

Requested Investigations: 9, Consultation GP **Estimated Cost :**

Prescriptions: 0030-183201-0391 - (FEXOFENADINE HCL : 120 MG) FILM COATED **Estimated :**
TABLETS,0009-149801-0151 - (CLOBETASOL PROPIONATE : 0.05%) CREAM,0444-348905-0971 - **Cost**
(CHOLECALCIFEROL : 10000 IU) SOFT GELATIN CAPSULES,

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 or other organization to release a medical condition & history for p insurance benefits.

Dr's Name : Enomen Goodluck

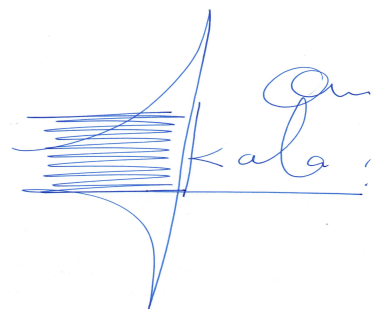
Stamp :

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

Patient 's
signature{Parent :
if minor}



Signature :



Date : 29-Oct-2024