

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : NARESH GENDA LAL
Card No : I035-029-118743875-01
Policy Holder : NARESH GENDA LAL
Payer Name : SALAMA – Islamic Arab Insurance Company
TPA : E CARE - Blue Network
Validity : 23-11-2023 To 22-11-2024
Gender : Male
Date Of Birth : 03-Aug-1993
Patient's Tel No : 0569644103

Service Date : 07-Nov-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: Pain during defecation. hard stools, constipation. Duration: 1week. There is no blood in stool.

Vitals: Temp : 36 Bp :130 Pulse :75 Resp :18

Clinical Findings:

Diagnosis: K60.2 - Anal fissure, unspecified, K64.9 - Unspecified hemorrhoids, Date of Onset : 07/18/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0097-103201-0391 - (CIPROFLOXACIN : 500 MG) FILM COATED TABLETS, 0086-225101-2091 - (POTASSIUM CHLORIDE : 46.6 MG) (POLYETHYLENE GLYCOL : 13.125 G) (SODIUM BICARBONATE : 178.5 MG) (SODIUM CHLORIDE : 350.7 MG) ORAL POWDER, 0027-149903-2231 - (DICLOFENAC SODIUM : 100 MG) RECTAL SUPPOSITORIES, 0071-158501-0391 - (HESPERIDIN : 50 MG) (DIOSMIN (FLAVONOIDIC FRACTION : 450 MG FILM COATED TABLETS,

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 :

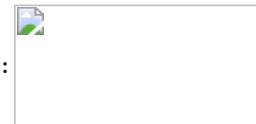
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Enomen Goodluck

Stamp :



Patient's signature {Parent : if minor}



Date : Nov-2024

Signature :

Date : 07-Nov-2024