Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **JUSTIN RODRIGUE ENDANG AMOUGOU**	**Service Date**	:**19-Nov-2024**
Card No	: **I005-029-121294570-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC**
Policy Holder	: **JUSTIN RODRIGUE ENDANG AMOUGOU**	**Doctor's Name**	:**Enomen Goodluck**
Payer Name	: **DUBAI INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **03-09-2024** To **02-09-2025**		
Gender	: **Male**		
Date Of Birth	: **15-Apr-1991**		
Patient's Tel No	: **0585839224**		

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 : PC: An unusal discomfort in the penis. Said to be aggravated with he presses on the the urethral. There is no frequency of urine, no straining, no pain on micturiction. **Duration:**

Vitals: Temp : 36.9 Bp :120 Pulse :88 Resp :18

Clinical Findings:

Diagnosis: N34.1 - Nonspecific urethritis, **Date of Onset** : 19/18/2024

Requested Investigations: 9, Consultation GP,81001, URNLS DIP STICK/TABLET REAGENT AUTO MICROSCOPY **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** : 19-Nov-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** : 19-Nov-2024