

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : JUSTIN RODRIGUE
ENDANG AMOUGOU
Card No : I005-029-121294570-01
Policy Holder : JUSTIN RODRIGUE
ENDANG AMOUGOU

Payer Name : DUBAI INSURANCE
COMPANY

TPA : E CARE - Blue Network

Validity : 03-09-2024 To 02-09-2025

Gender : Male

Date Of Birth : 15-Apr-1991

Patient's Tel No : 0585839224

Service Date :20-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 : Duration :

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

Clinical Findings:

Diagnosis: N34.1 - Nonspecific urethritis,R30.9 - Painful micturition, unspecified, Date of Onset :20/09/2024

Requested Investigations: 0195-107704-0802, CEFTRIAXONE-TABUK IM,96372, THER/PROPH/DIAG Estimated Cost :
INJ SC/IM,9.01, Follow Up Consultation GP

Prescriptions: 0097-127405-0391 - (AZITHROMYCIN : 500 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 :

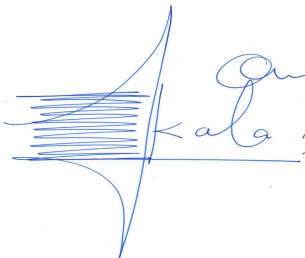
Dr. Enomen Goodluck Ekata
General Practitioner
DHA No: 28040827-001
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

Patient 's signature{Parent : if minor}



Date : Nov-2024

Signature :



Date : 20-Nov-2024