Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: MOHAMED ENAYATULLAH KHAN**
Card No	**: I040-029-117305023-01**
Policy Holder	**: MOHAMED ENAYATULLAH KHAN**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 02-01-2024** To **01-01-2025**
Gender	**: Male**
Date Of Birth	**: 29-Nov-1978**
Patient's Tel No	**: 0563014230**

Service Date **:28-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: Complaint of bad smell in his stool There is no abdominal pain, no change in bowel habit, no fever, no blood or mucus in stool Patient is reassurred and reminded that stool is supposed to be smelly. Counselled to avoid high protein diet for a few days and deal more vegetables and fruits. **Duration:**

Vitals: Temp : 36.8 Bp :130 Pulse :78 Resp :18

Clinical Findings:

Diagnosis: K52.9 - Noninfective gastroenteritis and colitis, unspecified, **Date of Onset** : 28/11/2024

Requested Investigations: 9, Consultation GP **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.

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** : 28-Nov-2024

Signature : **Date** : 28-Nov-2024