## Administrative

# MEDICAL CLAIM FORM

## Claim Ref:

| | |
|---|---|
| **Patient Name** | **: JEET BAHADUR KHATRI** |
| **Card No** | **: I040-029-120209240-01** |
| **Policy Holder** | **: JEET BAHADUR KHATRI** |
| **Payer Name** | **: UNION INSURANCE COMPANY** |
| **TPA** | **: E CARE - Blue Network** |
| **Validity** | **: 02-01-2024** To **01-01-2025** |
| **Gender** | **: Male** |
| **Date Of Birth** | **: 02-Aug-1980** |
| **Patient's Tel No** | **: 0504753940** |

**Service Date** :**16-Dec-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 :** For follow up A known hypertensive not compliant with medications. Has not had his BP medicines for over 2 weeks. BP today is 160/100mmhg C/o: headache and low back pain. **Duration:**

**Vitals:**Temp : 36.8 Bp :160 Pulse :92 Resp :18

**Clinical Findings:**

**Diagnosis:** I10 - Essential (primary) hypertension,R51.9 - Headache, unspecified,M54.5 - Low back pain, **Date of Onset** :16/24/2024

**Estimated Cost** :

**Requested Investigations:** 9, Consultation GP

**Prescriptions:** 2093-596002-0431 - (DICLOFENAC DIETHYLAMINE : 23.2 MG / G GEL,1217-373201-2401 - (TOLPERISONE : 150 MG) SUGAR COATED TABLETS,3735-377602-0391 - (PARACETAMOL : 500 MG (CODEINE PHOSPHATE : 30 MG FILM COATED TABLETS,0207-379202-1171 - (AMLODIPINE (AS BESYLATE : 10 MG 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 :** 16-Dec-2024

**Signature :** **Date** : 16-Dec-2024