Administrative

MEDICAL CLAIM FORM

Claim Ref:

DEEPAK KUMAR . **Patient** Name

RAVEENDRA

Service Date :27-Dec-2024

Network

: Green

Health Provider :CITICARE MEDICAL CENTER LLC

Direct Access SP - YES

Card No

: 1040-029-120358979-01

DEEPAK KUMAR.

Doctor's Name

:Enomen Goodluck

Policy Holder: Payer Name : UNION INS

Validity

RAVEENDRA UNION INSURANCE

Co-Insurance

CONSULTATION LAB/RADIOLOGY PHYSIO PHARMACY IP MATERNITY DENTAL NIL NIL LIMIT ||NIL ||10% 10% max NIL NA

TPA : E CARE - Blue Network

: 02-01-2024 To 01-01-2025

Gender : Male

Date Of Birth: 08-Jan-1986 Patient's Tel : 0547325221 Remarks

☐ Acute	e Pre-existing and chronic			☐ Maternity	
No history of trauexamination is es	uma. No fever, no flu symptoi sentially normal. TMJ arthro p :130 Pulse :60 Resp :18	ms, no ear sy	•	ys. Duration:	
Diagnosis: M26.651 - Arthropathy of right temporomandibular joint, Date of Onset :27/57/2024					
Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,9, Consultation GP				Estimated : Cost	.27/37/2024
•	17-373201-2401 - (TOLPERIS NAC POTASSIUM : 50 MG) PO		G) SUGAR COATED TABLETS,0027- OLUTION,	.142201- 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 : Enor Name	nen 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}	27- Date : Dec- 2024
Signature :	La la !	Date : 2	:7-Dec-2024		