

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name

: VIGNESHKUMAR LAKSHMANAN LAKSHMANAN

Card No

: I005-029-119704083-01

Policy Holder

: VIGNESHKUMAR LAKSHMANAN LAKSHMANAN

Payer Name

: DUBAI INSURANCE COMPANY

TPA

: E CARE - Blue Network

Validity

: 08-08-2024 To 07-08-2025

Gender

: Male

Date Of Birth

: 23-Jan-1994

Patient's Tel No

: 0523864580

Service Date

: 28-Dec-2024

Health Provider

: CITICARE MEDICAL CENTER LLC

Doctor's Name

: Enomen Goodluck

Co-Insurance

Network

: Green

Direct Access SP - YES

Remarks

:

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 :

Duration :

Vitals:

Clinical Findings:

Diagnosis: L03.115 - Cellulitis of right lower limb,L60.0 - Ingrowing nail,R52 - Pain, unspecified,

Date of Onset :28/55/2024

Requested Investigations: 51.01, Non-surgical cleansing with surgical dressing 16 sq inches / 100 sq centimeters or less,9.01, Follow Up Consultation GP

Estimated Cost :

Prescriptions:

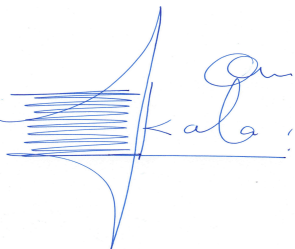
MEDICAL PRACTITIONER DECLARATION :

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

Signature :



Stamp :

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

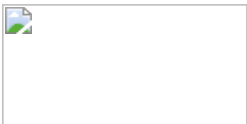
Date

: 28-Dec-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

: 28-Dec-2024