

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : Sachin Pandurang Vinherkar

Card No : 1040-029-113718954-01

Policy Holder : Sachin Pandurang Vinherkar

Payer Name : UNION INSURANCE COMPANY

TPA : E CARE - Blue Network

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

Gender : Male

Date Of Birth : 07-Jan-1984

Patient's Tel No : 0503667303

Service Date :30-Dec-2024

Health Provider :CITICARE MEDICAL CENTER LLC

Doctor's Name :Enomen Goodluck

Co-Insurance :

Remarks :

Network : Green

Direct Access SP - YES

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 : Fever, cough and generalized body pains, Duration: 21/12/2024 Positive history of atopy not hypertensive and not diabetic.

Vitals:Temp : 36.9 Bp :128 Pulse :88 Resp :18

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,J30.9 - Allergic rhinitis, unspecified,R07.0 - Pain in throat,

Estimated Cost :

Requested Investigations: 9, Consultation GP,9, Consultation GP

Prescriptions: 0027-265802-1161 - (BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V) SYRUP,1516-107902-1171 - (IBUPROFEN : 400 MG) TABLETS,0252-389902-1171 - (LORATADINE : 5 MG (PSEUDOEPHEDRINE SULPHATE : 120 MG TABLETS,

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

Stamp :

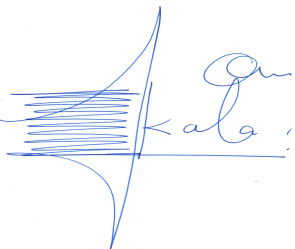
Dr. Enomen Goodluck Ekata

General Practitioner

DHA No: 28040827-001

CITICARE MEDICAL CENTER LLC

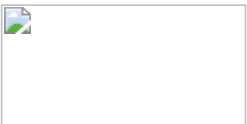
DUBAI - U.A.E.

Signature : 

Date : 31-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}



31-Dec-2024

Date : Dec-2024