Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: SHALIKA MADUWANTHI KULAWANSHA KARUNA PELIGE
Card No	: I040-029-119668661-01
Policy Holder	: SHALIKA MADUWANTHI KULAWANSHA KARUNA PELIGE
Payer Name	: UNION INSURANCE COMPANY
TPA	: E CARE - Blue Network
Validity	: 02-01-2025 To 01-01-2026
Gender	: Female
Date Of Birth	: 20-Feb-1996
Patient's Tel No	: 0561360824

Service Date	:02-Jan-2025
Health Provider	:CITICARE MEDICAL CENTER LLC
Doctor's Name	:Enomen Goodluck

Network : Green

Direct Access SP - YES

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 : **Duration :**

Vitals: Temp : 36.6 Bp :128 Pulse :88 Resp :18

Clinical Findings:

Diagnosis: J03.90 - Acute tonsillitis, unspecified,R50.9 - Fever, unspecified, **Date of Onset** :02/26/2025

Requested Investigations: 9, Consultation GP **Estimated Cost :**

Prescriptions: **Estimated Cost :**

MEDICAL PRACTITIONER DECLARATION :

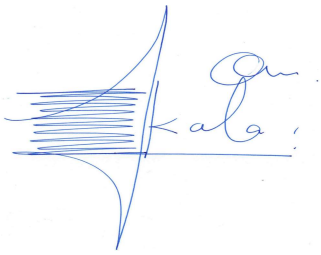
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

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 : 02-Jan-2025

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 : 02-Jan-2025