Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: SABNAM SHERPA**
Card No	**: I040-029-120704972-01**
Policy Holder	**: SABNAM SHERPA**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 02-01-2025** To **01-01-2026**
Gender	**: Female**
Date Of Birth	**: 08-Mar-2001**
Patient's Tel No	**: 0503387088**

Service Date :**02-Jan-2025** **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 : PC: Pruritic lesion on the webspace of the 4th and 5th toe of right foot duration: 2weeks **Duration:**

Vitals: Temp : 36.9 Bp :112 Pulse :84 Resp :22

Clinical Findings:

Diagnosis: L30.9 - Dermatitis, unspecified,L29.8 - Other pruritus, **Date of Onset** : 02/15/2025

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0030-183201-0391 - (FEXOFENADINE HCL : 120 MG) FILM COATED TABLETS,0031-109204-1172 - (TERBINAFINE (AS HCL) : 250 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** : 02-Jan-2025

Signature : **Date** : 02-Jan-2025