Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: RAJAN JOSEPH JOSEPH RAJAPPAN**
Card No	**: I040-029-117773737-01**
Policy Holder	**: RAJAN JOSEPH JOSEPH RAJAPPAN**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 02-01-2025** To **01-01-2026**
Gender	**: Male**
Date Of Birth	**: 25-May-1977**
Patient's Tel No	**: 0588074897**

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: High grade fever, pain in throat, cough and headache duration: 2 days (1/01/2025). Associated inability to taste and smell. A known diabetic on routine medications. not hypertensive. COVID 19 suspected, patient unwilling to be screened. **Duration:**

Vitals: Temp : 36.7 Bp :130 Pulse :110 Resp :22

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,J01.90 - Acute sinusitis, unspecified,J30.9 - Allergic rhinitis, unspecified, **Date of Onset** :02/28/2025

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,96365, THER/PROPH/DIAG IV INF INIT,0005-149902-1021, CLOFEN ,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,96372, THER/PROPH/DIAG INJ SC/IM,82947, GLUCOSE QUANTITATIVE BLOOD XCPT REAGENT STRIP,9, Consultation GP **Estimated Cost** :

Prescriptions: 0097-127405-0392 - (AZITHROMYCIN : 500 MG) FILM COATED TABLETS,0250-125808-1741 - (POVIDONE IODINE : 1%) GARGLE,0005-116801-1162 - (SODIUM CITRATE : 57 MG/5ML) (AMMONIUM CHLORIDE : 131.5 MG/5 ML) (MENTHOL : 1.1 MG/5 ML) (DIPHENHYDRAMINE : 13.5 MG/5ML) SYRUP,0252-389902-1171 - (LORATADINE : 5 MG) (PSEUDOEPHEDRINE SULPHATE : 120 MG) TABLETS,1516-107902-1171 - (IBUPROFEN : 400 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

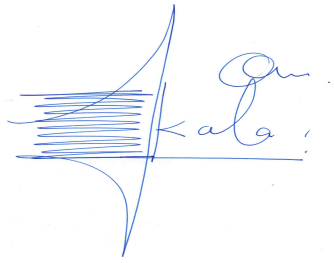
Stamp :

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