Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: NAGABHISHEK BANGALORE**
Card No	**: I005-029-119344150-04**
Policy Holder	**: NAGABHISHEK BANGALORE**
Payer Name	**: DUBAI INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 28-05-2024** To **27-05-2025**
Gender	**: Male**
Date Of Birth	**: 22-Sep-1995**
Patient's Tel No	**: 055552722**

Service Date :09-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 : fever, cough, runny nose, throat pain, generalized body pain duration: 3 days **Duration:**
on exam: throat is inflamed, hyperemic.

Vitals: Temp : 37.5 Bp :115 Pulse :113 Resp :18

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,J30.9 - Allergic rhinitis, unspecified,R50.9 - Fever, unspecified, **Date of Onset** :17/56/2025

Requested Investigations: 2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,0005-149902-1021, CLOFEN ,0248-122107-1021, DEXAMETHASONE SODIUM PHOSPHATE,0195-107704-0801, CEFTRIAXONE-TABUK IV,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,96365, THER/PROPH/DIAG IV INF INIT,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP,96374, THER/PROPH/DIAG INJ IV PUSH,0195-107704-0801, CEFTRIAXONE-TABUK IV **Estimated Cost** :

Prescriptions: 0005-116801-1161 - (SODIUM CITRATE : 57 MG/5ML) (AMMONIUM CHLORIDE : 131.5 MG/5 ML) (MENTHOL : 1.1 MG/5 ML) (DIPHENHYDRAMINE : 13.5 MG/5ML) SYRUP,0005-119805-1172 - (PREDNISOLONE : 5 MG TABLETS,2027-560101-0392 - (IBUPROFEN : 150 MG (PARACETAMOL : 500 MG FILM COATED TABLETS,0252-389902-1171 - (LORATADINE : 5 MG) (PSEUDOEPHEDRINE SULPHATE : 120 MG) TABLETS,0097-127405-0392 - (AZITHROMYCIN : 500 MG) FILM COATED 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** : 17-Jan-2025

Signature : **Date** : 17-Jan-2025