

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : SUPUN PRIYAKELUM

Card No : I011-029-120781209-03

Policy Holder : SUPUN PRIYAKELUM

Payer Name : AL SAGR NATIONAL INSURANCE COMPANY

TPA : E CARE - Blue Network

Validity : 08-06-2024 To 07-06-2025

Gender : Male

Date Of Birth : 19-Mar-1989

Patient's Tel No : 0529671089

Service Date :19-Jan-2025

Health Provider :CITICARE MEDICAL CENTER LLC

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 :

Network : Green

Direct Access SP - YES

☐ Acute

☐ Pre-existing and chronic

☐ Maternity

Chief Complaints : pain in abdomen since 3 to 4 hours,umbilical area and right side of abdomen. o/e there is no positive mac burnis point,abdomen is tender and pain starting right side and than in upper umbilical area

Duration:

Vitals:Temp : 36.8 Bp :130 Pulse :90 Resp :18

Clinical Findings:

Diagnosis: R14.0 - Abdominal distension (gaseous),R52 - Pain, unspecified,

Date of Onset :19/03/2025

Requested Investigations: 0005-136504-1021, SCOPINAL,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP

Estimated Cost :

Prescriptions: 0005-136501-0392 - (HYOSCINE : 10 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.

Dr's Name : Enomen Goodluck

Stamp :

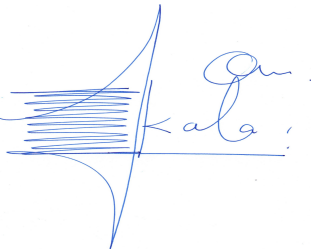
Dr. Enomen Goodluck Ekata

General Practitioner

DHA No: 28040827-001

CITICARE MEDICAL CENTER LLC

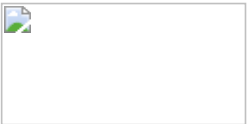
DUBAI - U.A.E.

Signature :

Date : 19-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 : Jan-2025