## 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** **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 :** 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 :** 19-Jan-2025