Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: Mansoor Ali Yameen Ali**
Card No	**: I040-029-113719090-01**
Policy Holder	**: Mansoor Ali Yameen Ali**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 02-01-2025** To **01-01-2026**
Gender	**: Male**
Date Of Birth	**: 25-Sep-1985**
Patient's Tel No	**: 0502245460**

Service Date **:27-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 : patient complaining of pain in big toe,previous report shows 6.8 uric acid,bodyache. **Duration:**

Vitals: Temp : 36.8 Bp :122 Pulse :94 Resp :0

Clinical Findings:

Diagnosis: I10 - Essential (primary) hypertension,M54.5 - Low back pain, **Date of Onset** :27/12/2025

Requested Investigations: 0005-149902-1021, CLOFEN ,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP,84550, URIC ACID BLOOD,80061, LIPID PANEL **Estimated Cost** :

Prescriptions: 4754-379201-1171 - (AMLODIPINE (AS BESYLATE : 5 MG TABLETS,0031-149904-1171 - (DICLOFENAC SODIUM : 50 MG TABLETS,0186-143702-0061 - (CELECOXIB : 100 MG) CAPSULES, **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** : 27-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 :** 27-Jan-2025