## Administrative

## MEDICAL CLAIM FORM

## Claim Ref:

| | |
|---|---|
| **Patient Name** | **: MOHAMED ENAYATULLAH KHAN** |
| **Card No** | **: I040-029-117305023-01** |
| **Policy Holder** | **: MOHAMED ENAYATULLAH KHAN** |
| **Payer Name** | **: UNION INSURANCE COMPANY** |
| **TPA** | **: E CARE - Blue Network** |
| **Validity** | **: 02-01-2025** To **01-01-2026** |
| **Gender** | **: Male** |
| **Date Of Birth** | **: 29-Nov-1978** |
| **Patient's Tel No** | **: 0563014230** |

**Service Date** :**02-Feb-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 :** itchng over abdomen and groin region o/e there is redness and rashes in groin region **Duration:**

**Vitals:**Temp : 36.8 Bp :130 Pulse :78 Resp :18

**Clinical Findings:**

**Diagnosis:** B35.6 - Tinea cruris,B35.4 - Tinea corporis, **Date of Onset** : 02/36/2025

**Estimated Cost** :

**Requested Investigations:** 9, Consultation GP

**Prescriptions:** 0027-109206-0151 - (TERBINAFINE (AS HCL : 1% CREAM,0186-140201-1451 - (FLUCONAZOLE : 150 MG) CAPSULES (HARD GELATIN),0320-148701-1171 - (LORATADINE : 10 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-Feb-2025

**Signature :** **Date** : 02-Feb-2025