

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 : itching 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 :

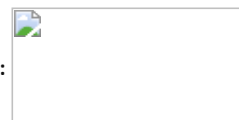
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

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 : Feb-2025

Signature :

Date : 02-Feb-2025