Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: CHIGOZIE FRANCIS ONWUASOANYA**
Card No	**: I040-029-117072633-01**
Policy Holder	**: CHIGOZIE FRANCIS ONWUASOANYA**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 02-01-2024** To **01-01-2025**
Gender	**: Male**
Date Of Birth	**: 04-Sep-1990**
Patient's Tel No	**: 971555429234**

Service Date :12-Apr-2024 **Network** : Green

Health Provider **:Irham Medical Center Arjan** **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 : C/o: pain in throat and nasal congestion with runing nose. **Duration :**

Vitals: Temp : 36.6 Bp :120 Pulse :88 Resp :18

Clinical Findings:

Diagnosis: J02.9 - Acute pharyngitis, unspecified,J03.90 - Acute tonsillitis, unspecified, **Date of Onset** :12/26/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 2027-560101-0392 - (IBUPROFEN : 150 MG) (PARACETAMOL : 500 MG) FILM COATED TABLETS,0252-185801-0391 - (DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 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
PESHAWAR MEDICAL CENTER LLC
DUBAI : U.A.E.

Signature : **Date** : 12-Apr-2024

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 :** 12-Apr-2024