Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: THI HA AUNG**
Card No	**: I040-029-120585630-01**
Policy Holder	**: THI HA AUNG**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 02-01-2024** To **01-01-2025**
Gender	**: Male**
Date Of Birth	**: 16-Feb-2001**
Patient's Tel No	**: 0559542312**

Service Date **:08-Sep-2024** **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 : Headache, fever, back pain, generalized body pains and low back pains Duration: 2days. Also has cough and pain in throat. **Duration:**

Vitals: Temp : 38.9 Bp :131 Pulse :117 Resp :18

Clinical Findings:

Diagnosis: J22 - Unspecified acute lower respiratory infection,R50.9 - Fever, unspecified,M79.10 - Myalgia, unspecified site,K29.00 - Acute gastritis without bleeding, **Date of Onset** :11/23/2024

Requested Investigations: 96365, THER/PROPH/DIAG IV INF INIT,0195-107704-0801, CEFTRIAXONE-TABUK IV,0005-149902-1021, CLOFEN ,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,2190-106618-1001, PARAFUSIV,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,0005-174202-0781, RISEK 40MG,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP **Estimated Cost** :

Prescriptions: 0067-230001-1161 - (DEXTROMETHORPHAN : 10 MG/5ML) (GUAIFENESIN : 100 MG/5ML) (PSEUDOEPHEDRINE : 30 MG/5ML) SYRUP,2027-560101-0392 - (IBUPROFEN : 150 MG) (PARACETAMOL : 500 MG) FILM COATED TABLETS,0139-116206-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 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

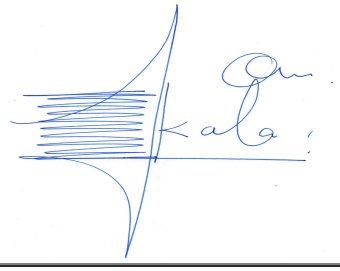
Stamp :

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 : 11-Sep-2024

Signature :



Date : 11-Sep-2024