

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : MEVAN DILSHAN PEIRIS
BADDE LIYANAGE DON

Card No : I040-029-118251299-01

Policy Holder : MEVAN DILSHAN PEIRIS
BADDE LIYANAGE DON

Payer Name : UNION INSURANCE
COMPANY

TPA : E CARE - Blue Network

Validity : 02-01-2024 To 01-01-2025

Gender : Male

Date Of Birth : 14-Jul-1995

Patient's Tel No : 0526048378

Service Date:22-Oct-2024

Health Provider :CITICARE MEDICAL CENTER LLC

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 :

Network : Green

Direct Access SP - YES

☐ Acute

☐ Pre-existing and chronic

☐ Maternity

Chief Complaints : PC: Low back pain Duration: 4days (18th/10/24) Pain is dull aching, and radiates to the lower limb. Pain is worst when rising from sitting to standing position.

Duration:

Vitals:Temp : 37.3 Bp :135 Pulse :75 Resp :18

Clinical Findings:

Diagnosis: M54.5 - Low back pain,M47.27 - Other spondylosis with radiculopathy, lumbosacral region,

Date of Onset :22/45/2024

Requested Investigations: 96372, THER/PROPH/DIAG INJ SC/IM,0005-149902-1021, CLOFEN ,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,9, Consultation GP

Estimated :
Cost

Prescriptions: 2093-596002-0432 - (DICLOFENAC DIETHYLAMINE : 23.2 MG / G) GEL,0090-122302-0391 - (ETORICOXIB : 120 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 :

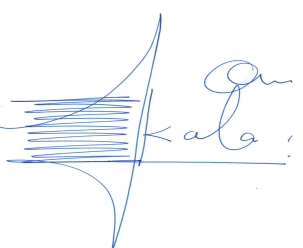
Dr. Enomen Goodluck Ekata

General Practitioner

DHA No: 28040827-001

CITICARE MEDICAL CENTER LLC

DUBAI - U.A.E.

Signature :

Date : 22-Oct-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 : Oct-2024