Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **MEVAN DILSHAN PEIRIS BADDE LIYANAGE DON**	**Service Date:**	**22-Oct-2024**
Card No	: **I040-029-118251299-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**
Policy Holder	: **MEVAN DILSHAN PEIRIS BADDE LIYANAGE DON**	**Doctor's Name**	**:Enomen Goodluck**
Payer Name	: **UNION INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **02-01-2024** To **01-01-2025**		
Gender	: **Male**		
Date Of Birth	: **14-Jul-1995**		
Patient's Tel No	: **0526048378**		

Network : Green

Direct Access SP - YES

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

☐ **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.

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 : 22-Oct-2024

Signature :

Date : 22-Oct-2024