Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **VISHAL KUMAR CHAUDHARY**	**Service Date**	:**24-Jul-2024** **Network** : Green
Card No	: **I011-029-119736610-02**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **VISHAL KUMAR CHAUDHARY**	**Doctor's Name**	:**Humaira**
Payer Name	: **AL SAGR NATIONAL INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **19-06-2024** To **18-06-2025**		
Gender	: **Male**		
Date Of Birth	: **06-Aug-1993**		
Patient's Tel No	: **0523004789**		

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 : **Duration :**

Vitals:

Clinical Findings:

Diagnosis: R50.9 - Fever, unspecified,J03.90 - Acute tonsillitis, unspecified,R04.0 - Epistaxis,K29.00 - Acute gastritis without bleeding,E86.0 - Dehydration, **Date of Onset** :24/25/2024

Requested Investigations: **Estimated Cost :**

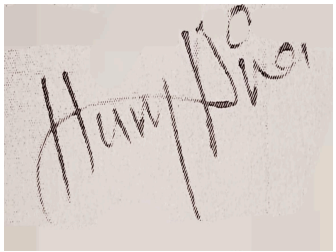
Prescriptions: **Estimated Cost :**

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 : Humaira **Stamp :**

Dr. Humaira Mumtaz
General Practitioner
DHA No: 54155530-002
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

Signature :  **Date** : 24-Jul-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 :** 24-Jul-2024