Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **JAHANGIR ALAM TAZUL ISLAM**	**Service Date**	:**06-Aug-2024** **Network** : Green
Card No	: **I040-029-118710008-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **JAHANGIR ALAM TAZUL ISLAM**	**Doctor's Name**	:**Humaira**
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	: **20-Apr-1978**		
Patient's Tel No	: **0568204143**		

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 : CO MUSCLE PAIN IN THE BACK SWEATING FOOT SWELLLINF MAY 2024 oe CHEST IS CLEAR NO ADDDED SOUNDS restless **Duration:**

Vitals: Temp : 36.5 Bp :120 Pulse :78 Resp :18

Clinical Findings:

Diagnosis: M62.838 - Other muscle spasm,R52 - Pain, unspecified, **Date of Onset** :06/22/2024

Requested Investigations: 101, GENARAL WELNES CHECKUP (55 TEST),9, Consultation GP **Estimated Cost :**

Prescriptions: 0027-142201-0831 - (DICLOFENAC POTASSIUM : 50 MG) POWDER FOR SOLUTION,2093-596002-0432 - (DICLOFENAC DIETHYLAMINE : 23.2 MG / G) GEL, **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.

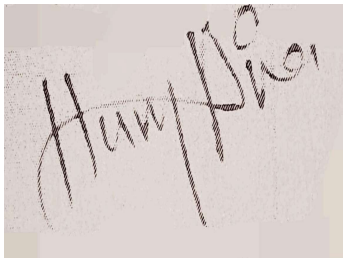
PATIENT'S DECLARATION :

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 : Humaira **Stamp :**

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

Patient 's signature{Parent if minor} : **Date :** 06-Aug-2024

Signature :  **Date** : 06-Aug-2024