Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: JEEVAN . GAIRE**
Card No	**: I040-029-120758200-01**
Policy Holder	**: JEEVAN . GAIRE**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 06-05-2024 To 01-01-2025**
Gender	**: Male**
Date Of Birth	**: 10-Oct-1996**
Patient's Tel No	**: 0521627307**

Service Date :09-Sep-2024 **Network** : Green

Health Provider :CITICARE MEDICAL CENTER LLC **Direct Access SP - YES**

Doctor's Name :AHSAN HUSSAIN

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 : PC: HEADACHE **Duration** :

Vitals: Temp : 36.2 Bp :127 Pulse :87 Resp :18

Clinical Findings:

Diagnosis: R51.9 - Headache, unspecified,R53.82 - Chronic fatigue, unspecified, **Date of Onset** :09/00/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 1217-373201-2401 - TOLPERISONE HCL,0005-107001-0051 - (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS,

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 : AHSAN HUSSAIN

Stamp :

Dr. Ahsan Hussain
General Practitioner
DHA No: 87543658-001
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

Signature :

Date : 09-Sep-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 : 09-Sep-2024