Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **MUHAMMAD YASIN MUHAMMAD BASHIR**	**Service Date**	**:11-Sep-2024**	**Network**	**:** Green
Card No	: **I017-029-115434050-02**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**		**Direct Access S**
Policy Holder	: **MUHAMMAD YASIN MUHAMMAD BASHIR**	**Doctor's Name**	**:Humaira**		
Payer Name	: **ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:		
TPA	: **E CARE - Green Network**				
Validity	: **01-10-2023** To **30-09-2024**				
Gender	: **Male**	**Remarks**	:		
Date Of Birth	: **10-May-1977**				
Patient's Tel No	: **0556858700**				

CONSULTATION	LAB/ RADIOLOGY	PHYSIO	PHARMACY	IP	MATEF
10% max	NIL	NIL	NIL LIMIT	NIL	10%

☐ **Acute** ☐ **Pre-existing and chronic** ☐ **Maternity**

Chief Complaints : co pimples on the face 3rd sep. 2024 oe chest is clear no added sounds stable **Duration:**

Vitals: Temp : 36.5 Bp :125 Pulse :81 Resp :18

Clinical Findings:

Diagnosis: R21 - Rash and other nonspecific skin eruption, **Date of Onset** : 11/0

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0250-125803-0651 - (POVIDONE IODINE : 10%) OINTMENT,0097-127405-0391 - (AZITHROMYCIN : 500 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 :

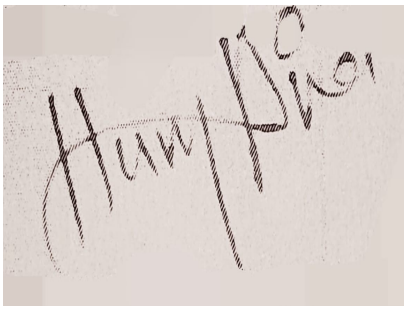
I hereby authorize any Healthcar or other organization to release a medical condition & history for p insurance benefits.

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}

Signature :  **Date :** 11-Sep-2024