

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name

: JEET BAHADUR KHATRI

Card No

: I040-029-120209240-01

Policy Holder

: JEET BAHADUR KHATRI

Payer Name

: UNION INSURANCE COMPANY

TPA

: E CARE - Blue Network

Validity

: 02-01-2024 To 01-01-2025

Gender

: Male

Date Of Birth

: 02-Aug-1980

Patient's Tel No

: 0504753940

Service Date

:13-Sep-2024

Health Provider

:CITICARE MEDICAL CENTER LLC

Doctor's Name

:Humaira

Co-Insurance

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

Remarks

:

Network

: Green

Direct Access SP

- YES

☐ Acute

☐ Pre-existing and chronic

☐ Maternity

Chief Complaints :

Duration :

Vitals:

Clinical Findings:

Diagnosis: J20.9 - Acute bronchitis, unspecified,R05 - Cough,R50.9 - Fever, unspecified,

Date of Onset :13/50/2024

Requested Investigations: 0188-135906-2441, PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION,94640, AIRWAY INHALATION TREATMENT,0195-107704-0802, CEFTRIAXONE-TABUK IM,96372, THER/PROPH/DIAG INJ SC/IM,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,INJ051, INJ-HYDROCORTISONE 100 MG/2ML,9, Consultation GP

Estimated Cost :

Prescriptions:

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.

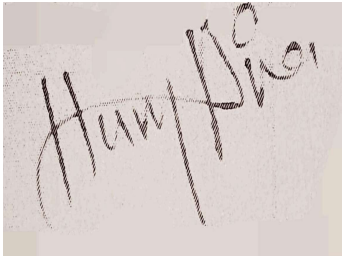
Dr's Name

: Humaira

Stamp :

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

Signature :



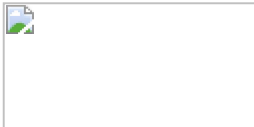
Date

: 13-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

: 13-Sep-2024