Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name : LAKAI MITRA JATINDRA MITRA MITRA
Card No : I040-029-113719086-01
Policy Holder : LAKAI MITRA JATINDRA MITRA MITRA
Payer Name : UNION INSURANCE COMPANY
TPA : E CARE - Blue Network
Validity : 02-01-2024 To 01-01-2025
Gender : Male
Date Of Birth : 05-Mar-1982
Patient's Tel No : 508842935

Service Date :19-Oct-2024
Health Provider :CITICARE MEDICAL CENTER LLC
Doctor's Name :AHSAN HUSSAIN
Network : Green
Direct Access SP - YES

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: itching in head fungal infection **Duration :**

Vitals: Temp : 36.4 Bp :120 Pulse :76 Resp :18

Clinical Findings:

Diagnosis: L23.89 - Allergic contact dermatitis due to other agents,R21 - Rash and other nonspecific skin eruption, **Date of Onset:**19/35/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Estimated Cost :

Prescriptions: 0006-149803-0651 - (CLOBETASOL PROPIONATE : 0.5 MG/G) OINTMENT,

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 : 19-Oct-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 : 19-Oct-2024