Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: NASHAAT MOHAMED AMIN ABOUABDALLA	**Service Date**	:24-Oct-2024	**Network**	: Green
Card No	: I005-029-119192245-03	**Health Provider**	:CITICARE MEDICAL CENTER LLC		**Direct Access SP - YES**
Policy Holder	: NASHAAT MOHAMED AMIN ABOUABDALLA	**Doctor's Name**	:AHSAN HUSSAIN		
Payer Name	: DUBAI INSURANCE COMPANY	**Co-Insurance**	:		
TPA	: E CARE - Green Network	**Remarks**	:		
Validity	: 24-02-2024 To 23-02-2025				
Gender	: Male				
Date Of Birth	: 13-Mar-1982				
Patient's Tel No	: 0525105406				

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 : PC: FUNNGAL INFECTION CORPORIS ' RINGWORM INFECTION ITCHING **Duration :**

Vitals: Temp : 37 Bp :122 Pulse :88 Resp :18

Clinical Findings:

Diagnosis: B35.4 - Tinea corporis,L23.89 - Allergic contact dermatitis due to other agents, **Date of Onset** :24/05/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0027-109204-1171 - (TERBINAFINE (AS HCL) : 250 MG) TABLETS,0027-109206-0151 - (TERBINAFINE (AS HCL) : 1%) CREAM, **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 : AHSAN HUSSAIN **Stamp :**

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

Patient 's signature{Parent if minor} : **Date :** 24-Oct-2024

Signature : **Date** : 24-Oct-2024