Administrative MEDICAL CLAIM FORM Claim Ref:

Service MANJUSHA :07-Nov-2024 Network : Green Date **ADLAKHA** :CITICARE MEDICAL CENTER LLC **Patient** Health : NARAYAN **Direct Access SP - YES** Name Provider LAL Doctor's **ADLAKHA** :Humaira Name Card No : R6604522 CONSULTATION LAB/RADIOLOGY PHYSIO PHARMACY IP MATERNITY DENTAL Co-**MANJUSHA** Insurance 10% max NIL NIL NIL LIMIT NIL 10% NA **ADLAKHA Policy** : NARAYAN Holder LAL Remarks: **ADLAKHA** Payer TAKAFUL : EMARAT Name : E CARE - Blue Network **TPA** Validity : 31-07-2024 To 30-07-2025 Gender : Female Date Of : 17-Oct-1979 Birth

Patient's : 0523668349 Tel No					
Acute	ite Pre-existing and chronic		☐ Maternity		
	slipped in the washroom cut near th	e eye but eye is ok pain is there 3	rd Duration:		
	r no addded sound restless				
Vitals: Temp: 36.6 Bp:1	16 Pulse :78 Resp :18				
Clinical Findings:					
	aceration w/o fb of left eyelid and p			te of Onset :07/50/2024	+
1 1	ss: 0005-149902-1021, CLOFEN -(FOR INJECTION,96372, THER/PR	•	Estimated : ltation Cost		
	903-0391 - (IBUPROFEN : 600 MO NE IODINE : 10%) OINTMENT,	G FILM COATED TABLETS,02:	Estimated : Cost		
MEDICAL PRACTITIONER DECLARATION:			PATIENT'S DECLARATION :		
I declare that I am the pa best of my knowledge tru	tient's medical practitioner and that ue and correct.	t the particulars given are to the	Employer or other or	y Healthcare provider, In ganization to release any Il condition & history for the benefits.	information
Dr's : Humaira Name	Stamp :	Dr. Humaira Mumtaz General Practitioner DHA No: 54155530-002 CITICARE MEDICAL CENTER LLC DUBAI - U.A.E.	Patient 's signature{Parent : if minor}		07- Date : Nov- 2024
Signature :	Date : 0'	7-Nov-2024			