Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: Mansoor Ali Yameen Ali**
Card No	**: I040-029-113719090-01**
Policy Holder	**: Mansoor Ali Yameen Ali**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 02-01-2024** To **01-01-2025**
Gender	**: Male**
Date Of Birth	**: 25-Sep-1985**
Patient's Tel No	**: 0502245460**

Service Date **:08-Nov-2024** **Network** : Green

Health Provider **:CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**

Doctor's Name **:AHSAN HUSSAIN**

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: fever 1 day flu epigastric pain nausea **Duration** :

Vitals:

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,J00 - Acute nasopharyngitis [common cold],K29.00 - Acute gastritis without bleeding,R11.2 - Nausea with vomiting, unspecified, **Date of Onset** :08/56/2024

Requested Investigations: 9, Consultation GP **Estimated Cost** :

Prescriptions: **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.

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 : 08-Nov-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 : 08-Nov-2024