Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: KYM CONWAY	**Service Date**	:14-Nov-2024
Card No	: I040-029-120347777-01	**Health Provider**	:CITICARE MEDICAL CENTER LLC
Policy Holder	: KYM CONWAY	**Doctor's Name**	:Humaira
Payer Name	: UNION INSURANCE COMPANY	**Co-Insurance**	
TPA	: E CARE - Blue Network	**Remarks**	:
Validity	: 15-01-2024 To 14-01-2025		
Gender	: Female		
Date Of Birth	: 02-Aug-1995		
Patient's Tel No	: 0585140175		

Network : Green

Direct Access SF

CONSULTATION	LAB/ RADIOLOGY	PHYSIO	PHARMACY	IP	MATEF
10% max	NIL	NIL	NIL LIMIT	NIL	10%

☐ **Acute** ☐ **Pre-existing and chronic** ☐ **Maternity**

Chief Complaints : **Duration :**

Vitals:

Clinical Findings:

Diagnosis: R22.9 - Localized swelling, mass and lump, unspecified, **Date of Onset** : 14/

Estimated Cost :

Requested Investigations: 9.01, Follow Up 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.

PATIENT'S DECLARATION :

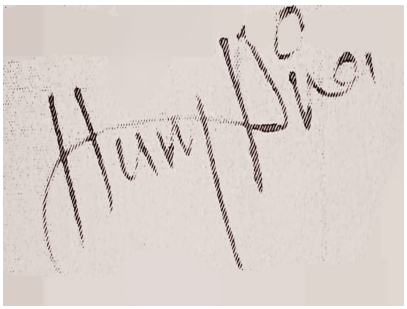
I hereby authorize any Healthcar or other organization to release a medical condition & history for p insurance benefits.

Dr's Name : Humaira

Stamp :

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

Patient 's signature{Parent if minor} :

Signature :  **Date :** 14-Nov-2024