Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: GINALYN LUMAYNO**	**Service Date**	**:15-Nov-2024**
Card No	**: I035-029-119729577-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**
Policy Holder	**: GINALYN LUMAYNO**	**Doctor's Name**	**:Humaira**
Payer Name	**: SALAMA – Islamic Arab Insurance Company**	**Co-Insurance**	**:**
TPA	**: E CARE - Green Network**	**Remarks**	**:**
Validity	**: 01-02-2024** To **31-01-2025**		
Gender	**: Female**		
Date Of Birth	**: 04-Dec-1977**		
Patient's Tel No	**: 000000000**		

Network : Green

Direct Access SP - YES

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 : co skin eruption on the hands knees exposed parts 3rd nov. 2024 oe chest is clear no added sounds restless **Duration:**

Vitals: Temp : 34 Bp :100 Pulse :87 Resp :0

Clinical Findings:

Diagnosis: R21 - Rash and other nonspecific skin eruption, **Date of Onset** : 15/40/2024

Requested Investigations: INJ051, INJ-HYDROCORTISONE 100 MG/2ML,96374, INJECTION SERVICE-IV,9, Consultation GP **Estimated Cost** :

Prescriptions: 0006-131401-0151 - (BETAMETHASONE : 0.1%) CREAM,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS, **Estimated Cost** :

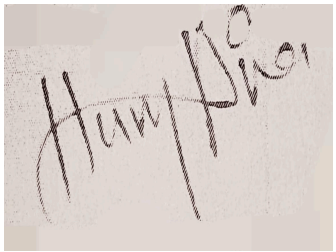
MEDICAL PRACTITIONER DECLARATION :

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 : Humaira

Stamp :

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

Signature : 

Date : 15-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 : 15-Nov-2024