Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **GINALYN LUMAYNO**	**Service Date**	:**22-Nov-2024**	**Network**	: Green
Card No	: **I035-029-119729577-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC**		**Direct Access SP - YES**
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	: **+971 52 201 8066**				

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 : 36.3 Bp :100 Pulse :87 Resp :0

Clinical Findings:

Diagnosis: R21 - Rash and other nonspecific skin eruption, **Date of Onset** : 27/30/2024

Requested Investigations: 9, Consultation GP,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN **Estimated Cost** :

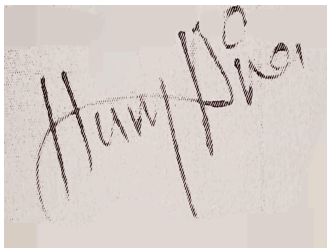
Prescriptions: **Estimated Cost** :

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 : Humaira **Stamp :**

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

Signature :  **Date** : 27-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** : 27-Nov-2024