Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: FETHI ACHI
Card No	: I040-029-121180791-01
Policy Holder	: FETHI ACHI
Payer Name	: UNION INSURANCE COMPANY
TPA	: E CARE - Blue Network
Validity	: 08-08-2024 To 01-01-2025
Gender	: Male
Date Of Birth	: 17-Nov-1999
Patient's Tel No	: 0581127489

Service Date :11-Dec-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 : **Duration** :

Vitals: Temp : 36.8 Bp :130 Pulse :80 Resp :18

Clinical Findings:

Diagnosis: **Date of Onset** : 11/09/2024

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.

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.

Dr's Name : AHSAN HUSSAIN **Stamp :**

Dr. Ahsan Hussain
General Practitioner
DHA No: 87543658-001
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

Patient 's signature{Parent if minor} : **Date :** 11-Dec-2024

Signature : **Date** : 11-Dec-2024