Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **ANISHA ANIL KATTIKKARAN**	**Service Date**	:**15-Dec-2024** **Network** : Green
Card No	: **I040-029-121542378-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **ANISHA ANIL KATTIKKARAN**	**Doctor's Name**	:**Humaira**
Payer Name	: **UNION INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **02-01-2024** To **01-01-2025**		
Gender	: **Female**		
Date Of Birth	: **29-Sep-1999**		
Patient's Tel No	: **0553685056**		

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 : **Duration :**

Vitals:

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,J30.9 - Allergic rhinitis, unspecified,R05 - Cough,E86.0 - Dehydration, **Date of Onset** :15/33/2024

Requested Investigations: 9, Consultation GP,0006-402803-2071, VENTOLIN NEBULES,94640, AIRWAY INHALATION TREATMENT **Estimated Cost** :

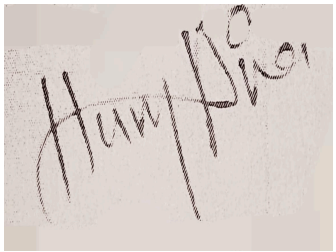
Prescriptions: **Estimated Cost** :

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** : 15-Dec-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-Dec-2024