Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: VIGNESHKUMAR LAKSHMANAN LAKSHMANAN**
Card No	**: I005-029-119704083-01**
Policy Holder	**: VIGNESHKUMAR LAKSHMANAN LAKSHMANAN**
Payer Name	**: DUBAI INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 08-08-2024** To **07-08-2025**
Gender	**: Male**
Date Of Birth	**: 23-Jan-1994**
Patient's Tel No	**: 0523864580**

Service Date	**:25-Dec-2024** **Network** : Green
Health Provider	**:CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Doctor's Name	**:Humaira**

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 : co nail ingron pus is coming 15th dec.20-24 oe chest is clear no added sounds restless **Duration:**

Vitals: Temp : 36.8 Bp :110 Pulse :78 Resp :18

Clinical Findings:

Diagnosis: L02.91 - Cutaneous abscess, unspecified,R50.9 - Fever, unspecified,R52 - Pain, unspecified, **Date of Onset :**25/14/2024

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,0195-107704-0801, CEFTRIAXONE-TABUK IV,96365, THER/PROPH/DIAG IV INF INIT,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP **Estimated Cost :**

Prescriptions: 0250-125803-0651 - (POVIDONE IODINE : 10%) OINTMENT,0195-116604-0391 - (METRONIDAZOLE : 500 MG FILM COATED TABLETS,0139-116207-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 500 MG) TABLETS,0005-107001-0051 - (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS, **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 :

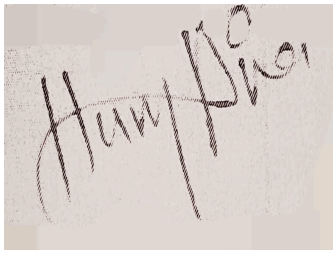
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : 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} :

Date : 25-Dec-2024

Signature : 

Date : 25-Dec-2024