

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : VIGNESHKUMAR LAKSHMANAN
Card No : I005-029-119704083-01
Policy Holder : VIGNESHKUMAR 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 : 28-Dec-2024
Health Provider : CITICARE MEDICAL CENTER LLC
Doctor's Name : Enomen Goodluck
Co-Insurance :

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

Network : Green
Direct Access SP - YES

Remarks :

☐ Acute	☐ Pre-existing and chronic	☐ Maternity
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Chief Complaints : Duration :

Vitals:

Clinical Findings:

Diagnosis: Date of Onset : 28/45/2024

Requested Investigations: 51.01, Non-surgical cleansing with surgical dressing 16 sq inches / 100 sq centimeters or less, 9.01, Follow Up Consultation GP Estimated Cost :

Estimated Cost :

Prescriptions:

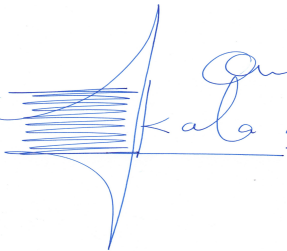
MEDICAL PRACTITIONER DECLARATION :
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

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 : Enomen Goodluck

Stamp :


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

Signature :  Date : 28-Dec-2024