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 **:28-Dec-2024** **Network** : Green

Health Provider **:CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**

Doctor's Name **:Enomen Goodluck**

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:

Clinical Findings:

Diagnosis: L03.115 - Cellulitis of right lower limb,L60.0 - Ingrowing nail,R52 - Pain, unspecified, **Date of Onset** :28/55/2024

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** :

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 : Enomen Goodluck **Stamp :**

Dr. Enomen Goodluck Ekata
General Practitioner
DHA No: 28040827-001
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

Patient 's signature{Parent if minor} : **Date** : 28-Dec-2024

Signature : **Date** : 28-Dec-2024