Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **VIGNESHKUMAR LAKSHMANAN LAKSHMANAN**	**Service Date**	:**31-Dec-2024**	**Network**	: Green
Card No	: **I005-029-119704083-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC**	**Direct Access SP - YES**	
Policy Holder	: **VIGNESHKUMAR LAKSHMANAN LAKSHMANAN**	**Doctor's Name**	:**Humaira**		
Payer Name	: **DUBAI INSURANCE COMPANY**	**Remarks**	:		
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**				

Co-Insurance :

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: L03.115 - Cellulitis of right lower limb,R52 - Pain, unspecified, **Date of Onset** : 31/28/2024

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

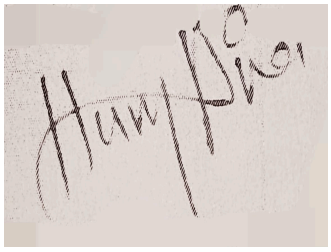
PATIENT'S DECLARATION :

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 : 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** : 31-Dec-2024

Signature :  **Date** : 31-Dec-2024