

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : NAGABHISHEK BANGALORE
Card No : I005-029-119344150-04

Policy Holder : NAGABHISHEK BANGALORE

Payer Name : DUBAI INSURANCE COMPANY

TPA : E CARE - Blue Network

Validity : 28-05-2024 To 27-05-2025

Gender : Male

Date Of Birth : 22-Sep-1995

Patient's Tel No : 055552722

Service Date :12-Jan-2025

Health Provider :CITICARE MEDICAL CENTER LLC

Doctor's Name :Enomen Goodluck

Network : Green

Direct Access SP - YES

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: J06.9 - Acute upper respiratory infection, unspecified,J30.9 - Allergic rhinitis, unspecified,R50.9 - Fever, unspecified, Date of Onset :12/00/2025

Requested Investigations: 9.01, Follow Up Consultation GP,0195-107704-0801, CEFTRIAXONE-TABUK IV,96365, THER/PROPH/DIAG IV INF INIT

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 :

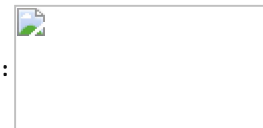
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Enomen Goodluck

Stamp :



Patient's signature{Parent : if minor}



Date : Jan-12-2025

Signature :

Date : 12-Jan-2025