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	**: 0585552722**

Service Date **:17-Jan-2025** **Network** : Green

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

Doctor's Name **:SANDIA**

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 : pc: nasal congestion 2 days headache 2 days 15/1/2025 **Duration :**

Vitals:

Clinical Findings:

Diagnosis: R09.81 - Nasal congestion,J01.00 - Acute maxillary sinusitis, unspecified, **Date of Onset** :22/16/2025

Estimated Cost :

Requested Investigations: 9.01, Follow Up Consultation GP

Prescriptions: 0005-128802-1971 - (XYLOMETAZOLINE HYDROCHLORIDE : 0.1% LIQUID FOR SPRAY (NASAL,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,

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.

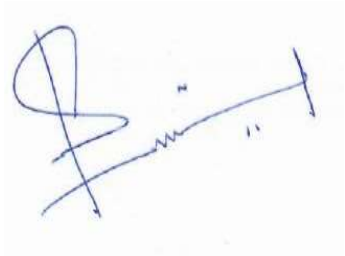
Dr's Name : SANDIA

Stamp :

Patient 's signature{Parent if minor} :

Date : 22-Jan-2025

Signature :



Date : 22-Jan-2025