Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: ADIN NAIDOO**
Card No	**: I005-029-119250085-01**
Policy Holder	**: ADIN NAIDOO**
Payer Name	**: DUBAI INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 16-10-2024** To **15-10-2025**
Gender	**: Male**
Date Of Birth	**: 10-Jul-2015**
Patient's Tel No	**: 0557230486**

Service Date **:29-Jan-2025** **Network** : Green

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

Doctor's Name **:DR Amaizah**

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: Temp : 36.8 Bp :0 Pulse :100 Resp :20

Clinical Findings:

Diagnosis: R50.9 - Fever, unspecified,R05 - Cough, **Date of Onset** : 29/48/2025

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0102-106704-1161 - (CHLORPHENIRAMINE : 0.75 MG/5 ML) (PARACETAMOL : 120 MG/5ML) (PSEUDOEPHEDRINE : 15 MG/5ML) SYRUP,

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 : DR Amaizah

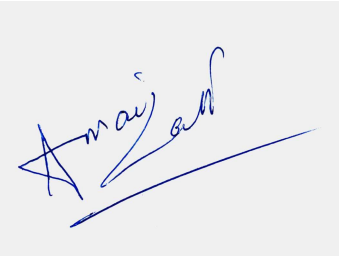
Stamp :

Dr. Amaizah Ishtiaq
General Practitioner
DHA: 98486553-001
CITICARE MEDICAL CENTER
DUBAI - U.A.E

Patient 's signature{Parent if minor} :

Date : 29-Jan-2025

Signature :



Date : 29-Jan-2025