Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **DEEPAK KUMAR . RAVEENDRA**	**Service Date**	**:01-Feb-2025** **Network** : Green
Card No	: **I040-029-120358979-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **DEEPAK KUMAR . RAVEENDRA**	**Doctor's Name**	**:Humaira**
Payer Name	: **UNION INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **02-01-2025** To **01-01-2026**		
Gender	: **Male**		
Date Of Birth	: **08-Jan-1986**		
Patient's Tel No	: **0547325221**		

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 : co pain in thefoot 25th jan. 2025 oe corn on the foot sole chest is clear no added sounds restless **Duration:**

Vitals: Temp : 36.8 Bp :120 Pulse :60 Resp :18

Clinical Findings:

Diagnosis: S90.812A - Abrasion, left foot, initial encounter, **Date of Onset** : 01/25/2025

Requested Investigations: 9, 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.

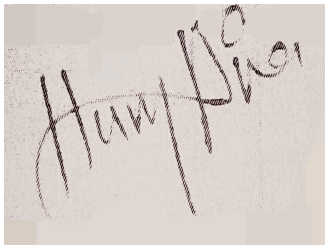
PATIENT'S DECLARATION :

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 : 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** : 01-Feb-2025

Signature :  **Date** : 01-Feb-2025