Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **IDRISSA JUMANNE LIKYPILA**	**Service Date**	:**08-Feb-2025** **Network** : Green
Card No	: **I040-029-121370818-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **IDRISSA JUMANNE LIKYPILA**	**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	: **20-Oct-1987**		
Patient's Tel No	: **0544525804**		

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 skin eruption on the scalp 1st feb . 2025 oe chest is clear no added sounds restless **Duration:**

Vitals: Temp : 36 Bp :128 Pulse :86 Resp :18

Clinical Findings:

Diagnosis: R21 - Rash and other nonspecific skin eruption,R51.9 - Headache, unspecified, **Date of Onset** :08/42/2025

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0278-107902-0391 - (IBUPROFEN : 400 MG) FILM COATED TABLETS,0006-131401-2261 - (BETAMETHASONE : 0.1%) SCALP SOLUTION,

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

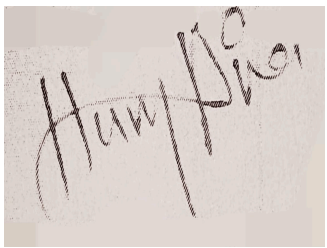
Stamp :

Dr. Humaira Mumtaz
General Practitioner
DHA No: 54155530-002
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

Patient 's signature{Parent if minor} :

Date : 08-Feb-2025

Signature :



Date : 08-Feb-2025