Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: HAYDAR ALI KHAN**
Card No	**: I040-029-113085013-01**
Policy Holder	**: HAYDAR ALI KHAN**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 30-03-2024** To **29-03-2025**
Gender	**: Male**
Date Of Birth	**: 17-Feb-1985**
Patient's Tel No	**: 0581504807**

Service Date :**10-Mar-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 : pc : pain , bleeding from thumb rt thumb after injury with kitchen knife o/e ; **Duration:**
3*3 cm laceration which is deep and without foreign body bleeding perfusely

Vitals: Temp : 36 Bp :140 Pulse :83 Resp :18

Clinical Findings:

Diagnosis: R21 - Rash and other nonspecific skin eruption,S61.112S - Laceration w/o fb of left thumb w damage to nail, sequela,R52 - Pain, unspecified,L03.90 - Cellulitis, unspecified, **Date of Onset** :10/01/2025

Requested Investigations: 12002, SMPL REPAIR SCALP/NECK/AX/GENIT/TRUNK 2.6 TO 7.5CM,0005-149902-1021, CLOFEN ,51.02, Non-surgical cleansing with surgical dressing between 16 sq inches / 100 sq centimeters and 48 sq inches / 300 sq centimeters,96372, THER/PROPH/DIAG INJ SC/IM,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,0195-107704-0802, CEFTRIAXONE-TABUK IM,96365, THER/PROPH/DIAG IV INF INIT,9, Consultation GP **Estimated Cost** :

Prescriptions: 0027-149907-0111 - (DICLOFENAC SODIUM : 75 MG) COATED TABLETS,0031-187502-0151 - (BETAMETHASONE : 0.10% (FUSIDIC ACID : 2% CREAM,0397-116206-1171 - (CLAVULANIC ACID : 125 MG (AMOXICILLIN : 875 MG 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 : DR Amaizah

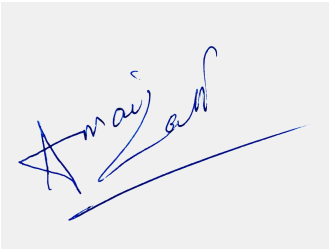
Stamp :

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

Patient 's signature{Parent if minor} :

Date : 10-Mar-2025

Signature :



Date : 10-Mar-2025