Administrative

MEDICAL CLAIM FORM

Claim Ref

Patient Name	: **HAYDAR ALI KHAN**	**Service Date**	:**23-Mar-2025**
Card No	: **I040-029-113085013-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC**
Policy Holder	: **HAYDAR ALI KHAN**	**Doctor's Name**	:**DR Amaizah**
Payer Name	: **UNION INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **30-03-2024** To **29-03-2025**		
Gender	: **Male**		
Date Of Birth	: **17-Feb-1985**		
Patient's Tel No	: **0581504807**		

Network : Green

Direct Access SP

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATEF
10% max	NIL	NIL	NIL LIMIT	NIL	10%

☐ **Acute** ☐ **Pre-existing and chronic** ☐ **Maternity**

Chief Complaints : FOLLOW UP FOR REMOVAL OF STITCHES **Duration :**

Vitals: Temp : 36.2 Bp :120 Pulse :64 Resp :18

Clinical Findings:

Diagnosis: S61.112S - Laceration w/o fb of left thumb w damage to nail, sequela,R52 - Pain, unspecified, **Date of Onse**

Requested Investigations: 15850, REMOVAL OF SUTURES,0005-149902-1021, CLOFEN ,51.01, Non-surgical cleansing with surgical dressing 16 sq inches / 100 sq centimeters or less,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP **Estimated Cost :**

Estimated Cost :

Prescriptions:

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 Healthca Employer or other organization regarding my medical condition 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} :

Signature :

Date : 23-Mar-2025