Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient

: HAYDAR ALI KHAN

Service Date :23-Mar-2025

Network : Green

Name

Health :CITICARE MEDICAL CENTER LLC

Card No : 1040-029-113085013-01

Provider Doctor's **Direct Access SP - YES**

Policy Holder: HAYDAR ALI KHAN

Name

:DR Amaizah

Payer Name : UNION INSURANCE COMPANY **Co-Insurance**

CONSULTATION LAB/RADIOLOGY PHYSIO PHARMACY IP MATERNITY DENTAL NIL NIL LIMIT ||NIL ||10% 10% max NIL NA

TPA

: E CARE - Blue Network

: 30-03-2024 To 29-03-2025

Validity

Remarks

Gender : Male

Date Of Birth: 17-Feb-1985 Patient's Tel . n581504807

☐ Acute ☐ Pre-exist	cute Pre-existing and chronic		☐ Maternity	
Chief Complaints: FOLLOW UP FOR RE	MOVAL OF STITCHE	S Duration	:	
Vitals:Temp: 36.2 Bp:120 Pulse:64 Re	esp :18			
Clinical Findings:				
Diagnosis: S61.112S - Laceration w/o f	b of left thumb w da	amage to nail, sequela,R52 - Pain,	unspecified, Date of Onset	:23/57/2025
Requested Investigations: 15850, REM	,		1, Non- Estimated :	
surgical cleansing with surgical dressing THER/PROPH/DIAG INJ SC/IM,9, Consu		sq centimeters or less,96372,	Cost	
	mated Cost	:		
Prescriptions:				
MEDICAL PRACTITIONER DECLARATION :			PATIENT'S 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.			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 : DR Amaizah Name	Stamp :	Dr. Amaizah Ishtiaq General Practitioner DHA: 98486553-001 Citicare Medical Center Dubai - U.A.E	Patient 's signature{Parent : if minor}	23- Date : Mar- 2025
Signature:	Date : 2	23-Mar-2025		