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 **:23-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 : 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 Onset :**23/32/2025

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 :**

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 : DR Amaizah

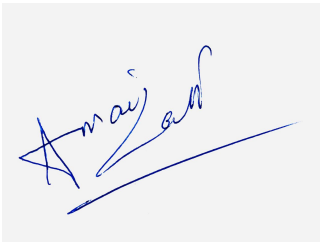
Stamp :

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

Patient 's signature{Parent if minor} :

Date : 23-Mar-2025

Signature :



Date : 23-Mar-2025