Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **SAMIR ELSAYED MOHAMED ALI GOMAA**	**Service Date**	:**24-Mar-2025** **Network** : Green
Card No	: **I040-029-121565065-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **SAMIR ELSAYED MOHAMED ALI GOMAA**	**Doctor's Name**	:**Humaira**
Payer Name	: **UNION INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Green Network**	**Remarks**	:
Validity	: **01-10-2024** To **30-09-2025**		
Gender	: **Male**		
Date Of Birth	: **17-Sep-1988**		
Patient's Tel No	: **0528156822**		

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 : fungal infection in right foot dermatitis in right side of waist patches over shoulder ledt side **Duration:**

Vitals: Temp : 36.6 Bp :117 Pulse :78 Resp :0

Clinical Findings:

Diagnosis: L23.9 - Allergic contact dermatitis, unspecified cause,B35.3 - Tinea pedis,B36.0 - Pityriasis versicolor,T78.49XS - Other allergy, sequela, **Date of Onset** :24/05/2025

Requested Investigations: 0005-111805-1021, CHLOROHISTOL 10MG,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP **Estimated Cost** :

Prescriptions: 0186-140201-1451 - (FLUCONAZOLE : 150 MG) CAPSULES (HARD GELATIN),0281-128401-0151 - (FUSIDIC ACID : 2% CREAM,0027-109206-0151 - (TERBINAFINE (AS HCL) : 1%) CREAM,0005-119803-1171 - (PREDNISOLONE : 20 MG) TABLETS,0320-148701-1171 - (LORATADINE : 10 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.

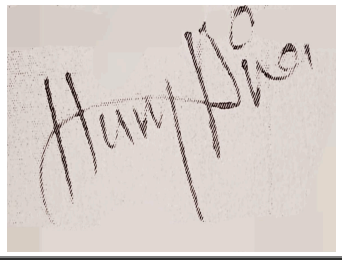
PATIENT'S DECLARATION :

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 : 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 :** 24-Mar-2025

Signature :  **Date** : 24-Mar-2025