Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: LIJIN . MATTANKOTT**	**Service Date**	**:03-Apr-2025** **Network** : Green
Card No	**: I005-029-115039052-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	**: LIJIN . MATTANKOTT**	**Doctor's Name**	**:Humaira**
Payer Name	**: DUBAI INSURANCE COMPANY**	**Co-Insurance**	
TPA	**: E CARE - Green Network**	**Remarks**	**:**
Validity	**: 01-06-2024** To **31-05-2025**		
Gender	**: Male**		
Date Of Birth	**: 16-Aug-1989**		
Patient's Tel No	**: 0522714238**		

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 : headache nausea ocassionly hypertension **Duration :**

Vitals: Temp : 35.7 Bp :139 Pulse :74 Resp :0

Clinical Findings:

Diagnosis: I10 - Essential (primary) hypertension,R51.9 - Headache, unspecified,R11.0 - Nausea, **Date of Onset :**03/19/2025

Estimated Cost :

Requested Investigations: 2, BASIC WELLNESS PANEL,9, Consultation GP

Prescriptions: 5252-168201-0391 - (DOMPERIDONE : 10 MG) FILM COATED TABLETS,0135-223401-1171 - (NAPROXEN : 500 MG) TABLETS,0207-379202-1171 - (AMLODIPINE (AS BESYLATE) : 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

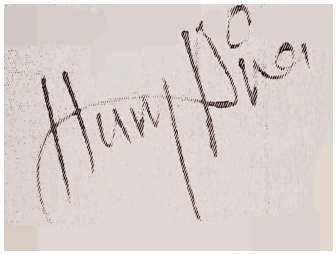
Stamp :

Dr. Humaira Mumtaz
General Practitioner
DHA No: 54155530-002
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

Patient 's signature{Parent if minor} :

Date : 03-Apr-2025

Signature :



Date : 03-Apr-2025